Medicaid 1915(c)
Home and Community-Based Services Waiver
For
Individuals with Mental Retardation and Other Related Conditions
(# 158.90)

STATE IMPLEMENTATION PLAN

Effective
July 1, 2005

Long Term Care Bureau
Division of Health Care Financing
Utah Department of Health

Approved by
CMS Region Office VIII

STATE OF UTAH

MEDICAID 1915(c) HOME AND COMMUNITY-BASED SERVICES WAIVER

For

INDIVIDUALS WITH MENTAL RETARDATION AND OTHER RELATED CONDITIONS

SECTION 1915(c) WAIVER FORMAT

1. The State of Utah requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a. ___ Yes b. X No

   If yes, the State assures that no more than 200 individuals will be served on this waiver at any one time.

   This waiver is requested for a period of (check one):

   a. ___ 3 years (Initial waiver)

   b. X 5 years (Renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a. ___ Nursing facility (NF)

   b. X Intermediate Care Facility for people with mental retardation (ICF/MR)

   c. ___ Hospital

   d. ___ NF (served in hospital)

   e. ___ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. ___ Aged (age 65 and older)

b. __ Disabled

c. ___ Aged and disabled

d. X* Mentally retarded*

*This waiver is limited to persons with disabilities who have established eligibility for State matching funds through the Utah Department of Human Services in accordance with UCA 62A-5.

*This waiver is limited to persons with mental retardation or persons with related conditions as defined in 42CFR 483.102(b)(3) and 42CFR435.1009.

e. ___ Developmentally disabled

f. ___ Mentally retarded and developmentally disabled

g. ___ Chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested in order to impose the following additional targeting restrictions (specify):

a. __ Waiver services are limited to the following age groups (Specify):

b. X Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

In addition the individual having mental retardation or related conditions, the individual must also meet the State requirements for admission into an ICF/MR as defined in R414-502, UAC. Individuals are required to meet the criteria on an ongoing basis.

c. ___ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by Public Law 100-203 to require active treatment at the level of care of an ICF/MR.

d. ___ Other criteria specified in Appendix C-4.

e. ___ not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a. X Yes b. ___ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy

a. X Yes b. ___ No c. ___ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. ___ Yes b. X No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. ___ Yes b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in appendix B-1 of this request, be included under this waiver:

a.	X	Behavior Consultation Service I
b.	X	Behavioral Consultation Service II
c.	X	Behavior Consultation Service III
d.	X	Chore Services
e.	X	Companion Services
f.	X	Day Supports - Site and Non-Site Based
g.	X	Environmental Adaptations
h.	X	Extended Living Supports
i.	X	Family Training and Preparation Services
j.	X	Family and Individual Training and Preparation Services –
k.	X	Financial Management Services
l.	X	Homemaker Services
m	X	Living Start-up Costs
n	X	Massage Therapy
o	X	Personal Assistance
p.	X	Personal Budget Assistance
q.	X	Personal Emergency Response System (PERS) – Monthly Fee
r.	X	Personal Emergency Response System (PERS) – Installation and Testing
s	X	Personal Emergency Response System (PERS) – Purchase
t.	X	Professional Medication Monitoring
u.	X	Residential Habilitation
v	X	Respite Care
w.	X	Respite Care – Intensive
x	X	Respite Care - Weekly
y.	X	Specialized Medical Equipment and Supplies - Monthly Fee
z.	X	Specialized Medical Equipment and Supplies - Purchase
aa..	X	Supported Employment
bb.	X	Supported Living
cc	X	Transportation Services (Non-Medical)
dd.	X	Waiver Support Coordinator Services

12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. A written individual support plan will be developed by qualified individuals for each individual served under this waiver. This individual support plan will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All waiver services will be furnished

pursuant to a written support plan. The individual support plan will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the individual support plan. FFP will not be claimed for waiver services that are not included in the individual written care plan.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board with the following exception(s) (Check all that apply):

a. X When provided as part of respite care in a facility approved by the State that is not a private residence (i.e. hospital, NF, foster home, or community residential facility).

b. ___ Meals furnished as part of a program of adult day health services.

c. ___ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3-meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of the individuals receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensing or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for the level of care when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.)

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

    1. Informed of any feasible alternatives under the waiver; and

    2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home and community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the waiver service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the setting(s) indicated in item 2 of this request, in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

i. X Yes ii. ___ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ___ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that individual support plans are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiency.

19. An effective date of July 1, 2005 is requested.

20. The State contact person for this request is Tonya Keller, who can be reached by telephone at (801) 538-9136.

This document, together with Appendices A through G, and all attachments, constitutes the State of Utah's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensing and certification requirements) will be kept on file at the Medicaid agency.

Signature: /s/.

Print name: Michael Deily.

Title: Director, Division of Health Care Financing.

Renewal Request Date: September 19, 2005.

APPENDIX A - ADMINISTRATION

APPENDIX A-1: LINE OF AUTHORITY FOR WAIVER OPERATION

Check one:

___ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

X The waiver will be operated by the Department of Human Services, Division of Services for People with Disabilities (DSPD), a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

___ The waiver will be operated by _____, a separate division within the single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES ROLE AND PROVIDER CONTRACTING REQUIREMENT

The Division of Services for People with Disabilities (DSPD) is the designated State Agency responsible for planning and developing an array of services and supports for persons with disabilities living in Utah. State statute 62A-5-103, 1953 as amended, sets forth DSPD's authority and responsibility to:

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve and monitor and conduct certification reviews of approved providers;
4. Act as a Fiscal Agent to receive and disburse funds; and
5. Develop standards and rules for the administration and operation of programs operated by or under contract with the division.

In accordance with DSPD's lead role and designated responsibilities, monies allocated for services for persons with disabilities are appropriated by the State Legislature to DSPD which in turn contracts with public and private providers for the delivery of services and supports necessary to implement all programs funded partially or in-full with State monies.

To assure the proper accounting for State funds, DSPD enters into a written State contract with each provider which includes a stipulation that claims for services provided be submitted to and paid by DSPD. This State-specific requirement applies regardless of whether: 1) the State funds are used for State-funds only programs or are used to draw down FFP as part of a 1915(c) HCBS Waiver program, or 2) the target population includes Medicaid-eligible citizens. The State contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Human Services.

In the case where a portion of the annual Legislative appropriation is designated for use as State matching funds for the Medicaid 1915(c) HCBS Waiver described herein, DSPD certifies to the State Medicaid Agency, through an interagency agreement, that the State funds will be transferred to the State Medicaid Agency in the amount necessary to reimburse the State match portion of actual Medicaid expenditures paid through the MMIS system for waiver services.

As a result of the State's organizational structure described above:

1. All providers participating in this 1915(c) HCBS Waiver must: a) fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) abide by the provision of the State contract to bill through DSPD for services provided.
2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system.
3. The State Medicaid Agency recovers from DSPD the State matching funds associated with the waiver expenditures.
4. The State Medicaid Agency approves all proposed rules, policies, and other documents related to the 1915(c) waiver prior to adoption by the DSPD policy board.

The requirement for State contracting with DSPD is reflected in Appendix B-2.

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

The State Medicaid Agency, in fulfillment of its mandated authority and responsibilities related to the 1915(c) HCBS Waiver program, retains responsibility for negotiating a Medicaid Provider Agreement with each provider of waiver services. This requirement is reflected in Appendix B-2. Unlike the DSPD State contract required of all providers of services to persons with disabilities who receive State monies, the Medicaid Provider Agreement is specific to providers of Medicaid funded services.

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement

delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;
5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for State match transfer);
7. Role Accountability and FFP Disallowances; and
8. Coordination of DHS Policy Development as it Relates to Implementation of the Medicaid Program.

APPENDIX A-2: INTRODUCTION TO THE HOME AND COMMUNITY-BASED SERVICES WAIVER FOR INDIVIDUALS WITH MENTAL RETARDATION AND OTHER RELATED CONDITIONS LIVING IN THE STATE OF UTAH

A. PURPOSE

The waiver is one means by which the Utah Division of Services for People with Disabilities seeks to fulfill its mission *to promote opportunities and provide supports for persons with disabilities to participate fully in Utah life.*

B. OBJECTIVES

This waiver is designed to meet the following objectives:

1. Promote access by waiver recipients to needed services and supports.

2. Provide supports that are adequate to assure the general health and safety of waiver recipients.

3. Maintain the health of individuals in waiver services sufficient to allow them to maintain their places of community residence.

4. Provide supports for waiver recipients to live as independently as possible in the community settings of their choice.

5. Provide supports that allow children and youth to reside with their families.

6. Improve waiver recipients' access to multiple community environments.

7. Promote the inclusion of people with disabilities in the activities and environments of their communities.

8. Foster mutually beneficial relationships among waiver recipients and people who do not have disabilities and who are not paid care givers for the purposes of expanding the natural support networks of waiver recipients and allowing waiver recipients to occupy socially valued roles in their communities.

9. Improve the waiver recipient's ability to perform activities of daily living and thereby achieve greater independence from care givers.

10. Provide the array of supports that allow the waiver recipients to demonstrate progress towards their valued outcomes.

C. PRINCIPLES

This waiver was designed to be consistent with a service delivery system that promotes and supports consumer self-determination, that maintains a high standard of quality in services and supports, and that maximizes the distribution and utilization of public funds, both federal and State. The waiver is, therefore, grounded in the following principles:

1. **Person-centered supports.** Person-centered supports are those that are articulated by the person or that directly relate to a goal, preference, or outcome that the person has identified as important. Person-centered supports, based upon quality of life as defined by the person with a disability, are superior to the prescriptions given by others who do not live with the disability. Person-centered supports reflect a shift in thought and practice grounded in the belief that the person who has the disability knows their needs and interests better than the professionals and para-professionals who come and go throughout that person's lifetime. The individual--assisted by legal representatives, family members and others in their chosen circle of support--has the authority to define the way in which she or he would like to live and the array of supports that best meets personal goals and individual needs.

2. **Consumer-driven supports.** Consumers, with adequate and appropriate information and with the assistance of legal representatives, family members, and others in their chosen circles of support, can define, decide, and direct the set of waiver services

authorized to be provided under the self-administered services model, that they receive. The informed preferences of the individual waiver recipient will be of primary importance in the decisions relevant to the selection and delivery of supports.

3. **Shared responsibility and risk.** As consumers exercise greater choice and control over the supports they receive, they also assume relevant responsibility and accept reasonable risk associated with the decisions that they make. The manner in which the waiver recipient, State agencies, and the providers of purchased supports share the responsibilities and risks related to services and supports will be defined by support plans, contracts, and other written agreements.

4. **Cost effectiveness.** Waiver recipients will receive adequate and appropriate services and supports. Further, wherever there are multiple, acceptable support options, waiver funding will be used to purchase the most cost effective among those options.

5. **Benefit to the consumer.** Supports purchased with waiver funding will be of clear benefit to the individual with a disability.

6. **Appropriate use of public funds.** The resources that the consumer will control will be used to secure supports defined by that individual's written support plan. The consumer will be asked to use non-public resources to secure services, supports, and/or assets that are not appropriate for purchase with public dollars, and, in the case of Medicaid waiver funds, are not directly associated with the prevention of institutionalization.

7. **No duplication.** Supports purchased with waiver funding will not be duplicative of each other or of supports purchased by other funding sources, public or private.

8. **Payor of last resort.** Waiver funds will be used for the purchase of supports only after supports available through the Medicaid State Plan and all other resources for which the individual is eligible have been maximized.

9. **Qualified providers.** Those whom the waiver recipient selects to provide supports under a purchase of service arrangement using waiver funds will meet the provider qualification as defined in this application.

10. **Quality assurance.** Service providers, support coordinators, and others who assist in the development and delivery of supports for people served through the Division of Services for People with Disabilities will be expected to maintain established standards of quality. The State Medicaid Agency and DSPD will assure that high standards are maintained by way of a comprehensive system of quality assurance including: (a) formal surveys of providers for measurement of individual and organizational outcomes, (b) contract compliance reviews, (c) regular observation and evaluation by support coordinators, (d) provider quality assurance systems, (e) consumer/family/legal representative satisfaction measures, (f) performance contracts with and reviews of State

agency staff, (g) audits completed by entities external to the agency, and (h) other oversight activities as appropriate.

D. DESCRIPTION OF ACCESS TO UTAH'S NON-WAIVER MEDICAID SERVICES

Following is a description of the ways in which waiver participants access general Medicaid services (Medicaid services which are not provided under the 1915(c) Waiver):

In Salt Lake, Utah, Weber, Davis, and Morgan counties, waiver participants receive physical health services through mandatory election of a managed care program, this is authorized through a 1915(b) Waiver.

Waiver participants in all other counties receive physical health services through a fee-for-service delivery system or by choosing to enroll in a managed care program.

In all but two counties, waiver participants access mental health services through the "Prepaid Mental Health Plan" a 1915(b) Waiver. The Prepaid Mental Health Plan provides mental health services necessary to diagnose, correct or ameliorate mental illness.

Mental health services in Wasatch and San Juan Counties are provided on a fee-for-service basis.

Statewide, participants having a dual diagnosis of mental illness and mental retardation, meeting the eligibility criteria for participation, may choose to receive mental health services and physical health services through UNI HOME, currently a 1915(b) Waiver. Utah is currently working with CMS to determine if UNI HOME would be more appropriately operated under 1915(a) Waiver authority. During the time an individual chooses to receive services through UNI HOME, the individual is not eligible to receive services through the Prepaid Mental Health Plan.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

By providing immediate assistance to waiver participants with an identified need, the services covered by this waiver, as described below, serve to prevent institutionalization of these individuals. The cost-effectiveness of the covered services is demonstrated in Appendix G.

The State authorizes waiver services to be provided through two service delivery methods as defined below:

Agency Based Provider Service delivery means the provision of services through a licensed or certified agency or through a contracted vendor. Under this method, individuals choose from which provider they wish to receive their waiver services. Services are then provided by the chosen agency. It is the responsibility of the provider agency to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, paying the wages etc. of the agency's employees. All waiver service categories are available under the Agency Based Provider Service delivery method.

Self-Administered Services means service delivery that is provided through a non-agency based provider. Self-Administered Services are made available to all waiver enrollees who elect to participate in this method. Support Coordinators provide ongoing oversight of the enrollees' ability to successfully utilize self-administered services. Family and Individual Training and Preparation services are available to recipients needing additional assistance and training in aspects of self-administration. Enrollees who subsequently demonstrate to their support coordinator their incapacity to successfully self-administer their services are transferred to Agency Based Provider Services.

Under Self-Administered Services, individuals and/or their chosen representatives hire individual employees to perform a waiver service/s. The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, etc. of the individual's employee/s. Individuals and/or their chosen representatives may avail themselves of the assistance offered them within the Family and Individual Training and Preparation Service should they request and/or be assessed as requiring additional support and assistance in carrying out these responsibilities.

In the case of an individual who cannot direct his or her own services, including minors and those who require a guardian, another person may be appointed as the decision-maker in accordance with applicable State law. The appointed person must perform supervisory activities at a frequency and intensity specified in the service plan. The individual or appointed person may also train the employee to perform assigned activities. Appointed decision-makers cannot also be providers of self-directed services.

Waiver participants and/or their representatives hire employees in accordance with Federal Internal Revenue Service ("IRS") and Federal and State Department of Labor ("DoL") rules and regulations (IRS Revenue Ruling 87-41; IRS Publication 15-A: *Employer's Supplemental Tax*

Guide; Federal DoL Publication WH 1409, Title 29 CFR Part 552, Subpart A, Section 3: *Application of the Fair Labor Standards Act to Domestic Service;* and States= *ABC Test*).

Individuals authorized to receive services under the Self Administered Services method may also receive services under the Agency Based Provider Services method in order to obtain the array of services that best meet the individual's needs.

Refer to Appendix E-2, Section A-(1) for information on Individual Support Plan and budget development.

For persons utilizing the Self-Administered Services method, Financial Management Services are offered in support of the self-administered option. Financial Management Services, (commonly known as a "Fiscal Agent") facilitate the employment of individuals by the waiver recipient or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, and (c) Medicaid claims processing and reimbursement distribution.

The individual receiving waiver services remains the employer of record, retaining control over the hiring, training, management, and supervision of employees who provide direct care services.

Once a person's needs have been assessed, the Individual Support Plan and budget have been developed and the individual chooses to participate in Self-Administered Services, the individual will be provided with a listing of the available Financial Management Services providers from which to choose. The individual will be referred to the Financial Management Services provider once a selection is made.

A copy of the individual's support plan/approved budget worksheet will be given to the chosen provider of Financial Management Services. The worksheet will indicate the person's total number of authorized funds. Allocated funds are only disbursed to pay for actual services rendered. All payments are made through Financial Management Services providers under contract with the Division of Services for People with Disabilities. Payments are not issued to the waiver recipient, but to and in the name of the employee hired by the person or their representative. The person will be authorized for a rate to cover the costs of the employee wages and benefits reimbursement.

The Support Coordinator monitors payments, reviews actual expenditure in comparison with the individual support plan and budget, contacts the waiver participant or their representative if any concerns arise, and assists in resolution of billing problems.

The Financial Management Services provider will have a working knowledge of the role and functions of payroll organizations and the administrative ability to function as a Financial Management Services provider. In addition, the Financial Management Services provider will have experience and supporting documentation in the following areas:

1. A Certified Public Accountant with 5 years experience is required.

2. Obtain a Federal Employer Identification Number (EIN) by filing the IRS Form SS-4, *Application for Employer Identification Number.*
3. Have a basic understanding of developmental disabilities.
4. Understand the philosophy and practice of Self-Administered Supports.
5. Have sufficient funds necessary to make payroll at least twice monthly or submit temporary payroll immediately following timecard payroll.
6. Maintain a Utah-based accounting department with accounting software capable of handling persons with multiple employees.
7. Documented approval from the Bureau of Medicaid Operations that the Financial Management Services provider's claims processing system is Medicaid compliant.

In support of self-administration, Financial Management Services will assist individuals in the following activities:

1. Verify that the employee completed the following forms
   a. Form I-9, including supporting documentation (i.e. copies of driver's license, social security card, passport). If fines are levied against the person for failure to report INS information, the Fiscal Agent shall be responsible for all such fines.
   b. Form W-4

2. Obtain a completed and signed Form 2678, Employer Appointment of Agent, from each person receiving services from the Financial Management Services provider, in accordance with IRS Revenue Procedure 70-6.

3. Provide persons with a packet of all required forms when using a Financial Management Services provider, including all tax forms (IRS Forms I-9, W-4 and 2678), payroll schedule, Financial Management Services provider's contact information, and training material for the web-based timesheet.

4. Process and pay DHS/DSPD approved employee timesheets, including generating and issuing paychecks to employees hired by the person.

5. Assume all fiscal responsibilities for withholding and depositing FICA and SUTA/FUTA payments on behalf of the person. Any federal and/or State penalties assessed for failure to withhold the correct amount and/or timely filing and depositing will be paid by the Financial Management Services provider.

6. Maintain a customer service system for persons and employees who may have billing questions or require assistance in using the web-based timesheet. The Financial Management Services provider will maintain an 800-number for calls received outside the immediate office area. Messages must be returned within 24 hours Monday thru Friday. Messages left between noon on Friday and Sunday evening shall be returned the following Monday.
   a. Must have capabilities in providing assistance in English and Spanish. Fiscal Agent must also communicate through TTY, as needed, for persons with a variety of disabilities.

7. File consolidated payroll reports for multiple employers. The Financial Management Services provider must obtain federal designation as Financial Management Services provider under IRS Rule 3504, (Acts to be Performed by Agents). A Financial Management Services provider applicant must make an election with the appropriate IRS Service Center via Form 2678, (Employer Appointment of Agent). The Financial Management Services provider must carefully consider if they want to avail the Employers of the various tax relief provisions related to domestics and family employers. The Financial Management Services provider may forego such benefits to maintain standardization. Treatment on a case-by-case basis is tedious, and would require retroactive applications and amended employment returns. The Financial Management Services provider will, if required, comply with IRS Regulations 3306(a)(3)(c)(2), 3506 and 31.3306(c)(5)-1 and 31.3506 (all parts), together with IRS Publication 926, Household Employer's Tax Guide. In order to be fully operational, the Form 2678 election should be postured to fall under two vintages yet fully relevant Revenue Procedures; Rev. Proc. 70-6 allows the Financial Management Services provider file one employment tax return, regardless of the number of employers they are acting for, provided the Financial Management Services provider has a properly executed Form 2678 from each Employer. Rev. Proc 80-4 amplifies 70-6, and does away with the multiple Form 2678 requirements, by imposing more stringent record keeping requirements on the Financial Management Services provider.

8. Obtain IRS approval for Agent status. The Financial Management Services provider shall consolidate the federal filing requirements, obtain approval for Utah State Tax Commission consolidated filings, and obtain approval for consolidated filing for unemployment insurance through the Department of Workforce Services. For those Employers retaining domestic help less than 40 hours per week, Workers Compensation coverage is optional. If the 40-hour threshold is achieved or exceeded, the Worker's Compensation Act requires coverage. Statutory requirements and the nature of insurance entail policies on an individual basis. Consolidated filings of Workers Compensation are not an option.

9. Financial Management Services provider cannot provide waiver recipients with community-based services in addition to Financial Management Services.

Behavior Consultation Service I

The provision of generally accepted educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in an ICF/MR and therefore, this service is intended to be *habilitative* in nature. Consultations are based upon the well-known and widely regarded principles of applied behavior coaching and focus on positive behavior supports. Behavioral consultants provide services to individuals whose behavior problems may be emerging, annoying, worrisome, objectionable, singular but not dangerous, and may interfere with learning or social relationships. The behaviors of the person shall not constitute an impending crisis, nor shall they be assessed as constituting a serious problem. The family and/or support staff with whom the Consultant is working will have no special needs/issues beyond consultation and skill training and will be capable of coordinating with schools, agencies, and others as needed. Consultation may include the development of a behavior program which employs widely accepted principles of applied behavior analysis that are applicable to many and which focus on the provision of positive behavioral supports (and which does not included any intrusive interventions). Services are to be provided in the person's residence or other naturally occurring environment in the community..

Limitations: This service will not be available to individuals who might otherwise receive this service through the Medicaid State Plan or any other funding source. .

X **Behavior Consultation Services-II**

The provision of educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in an ICF/MR and therefore, this service is intended to be *habilitative* in nature. Interventions are based upon the principles of applied behavior analysis and focus on positive behavior supports. Behavior consultants provide individual behavior consultation to families and/or staff who support individuals with *serious* though not potentially life threatening behavioral problems that may be complicated by medical or other factors. Problems addressed by behavior consultants are identified as serious, but have not been judged to be treatment resistant or refractory. Consultation shall include designing and training the family and/or support staff on a behavior support plan developed specifically for the person being served. Services are to be provided in the person's residence or other naturally occurring environment in the community. This service is consultative in nature and does not include the provision of any direct services to consumers.

Limitations: Contractors are not permitted to provide direct care to persons (i.e. bathing, feeding, dressing, or supervision) nor are they allowed to transport persons receiving

services. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.

X **Behavior Consultation Service-III**

The provision of educational procedures and techniques that are designed to decrease problem behavior and increase appropriate replacement behaviors. This service is intended to assist individuals in acquiring and maintaining the skills necessary for the capacity to live independently in their communities and avoid placement in an ICF/MR and therefore, this service is intended to be *habilitative* in nature. Interventions are based upon the principles of applied behavior analysis and focus on positive behavior supports. Behavioral consultants provide individual behavioral consultation to families and/or staff who support individuals with the most *involved, complex, difficult, dangerous*, potentially *life threatening* and resistant to change behavioral problems. The serious behavioral problems may be complicated by medical or other factors. In addition, eligible persons must have failed alternative interventions and are severely limited in their activities and opportunities due to their behavioral problems. Consultation shall include designing and training the family and/or support staff on a behavior support plan developed specifically for the person being served. Services are to be provided in the person's residence or other naturally occurring environment in the community. This service is consultative in nature and does not include the provision of any direct services to consumers.
Limitations: Contractors are not permitted to provide direct care to persons (i.e. bathing, feeding, dressing, or supervision) nor are they allowed to transport persons receiving services. This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.

X **Chore Services**

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress.

The Chore Services category may be provided under the Agency-Based Services or the Self-Administered Services method.

Limitations: These services will be provided only in the case where no other relative, care giver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization. Individuals receiving any other service contained within this waiver that may duplicate the provision of Chore Services are not eligible to receive Chore Services. This service is not available to foster children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Companion Services**

Involve non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the Individual Support Plan, and is not purely diversional in nature.

The Companion Services category may be provided under the Agency-Based Services or the Self-Administered Services method.

Limitations: Companion Services are not available to individuals receiving other waiver services in which the services are essentially duplicative of the tasks defined in Companion Services. Individuals receiving services within the Day Supports or Supported Living may receive Companion Services only on an hourly and not a daily basis, when the need exists and approval has been granted in advance for the utilization of this service by the appropriate DSPD region. This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Day Supports**

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that typically takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services are most commonly provided in licensed day-training or other habilitative facilities, or in integrated community settings with individuals without disabilities (not including staff paid to support the person). Services shall normally be furnished on routine workdays on a regularly scheduled basis. Day supports shall focus on enabling the individual to attain or maintain his or her maximum functional level. Day supports are offered on an hour and intermittent basis as well as on a daily basis. The nature of the Day Supports services offered to each individual is based upon an assessment of the needs of the individual at the time and may change over time.

Elements of Day Supports – Site and Non-Site Based category:

Site Based Day Supports – services provided in a licensed setting in which 4 or more individuals attend.

Non-Site Based Day Supports – designed to take place in the community and are driven by the individual's preferences.

Day Supports – Senior Supports – designed for individuals who have needs that closely resemble those of older persons who desire a lifestyle consistent with that of the community's population of similar age or circumstances. The support is intended to facilitate independence, promote community inclusion and prevent isolation.

Limitations: Individuals receiving Day Supports are not eligible to receive separate, individual waiver services in addition to this service if the separate service is essentially duplicative of the tasks defined in Day Supports. Individuals receiving Day Supports services may not receive the Extended Living service simultaneously.
This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Environmental Adaptations**

Adaptations involve equipment and/or physical adaptations to the individual's residence and/or vehicle that are necessary to assure the health, welfare and safety of the individual or enhance the individual's level of independence. The equipment/adaptations are identified in the individual's support plan and a qualified professional specifies the model and type of equipment. The adaptations may include purchase, installation, and repairs. Such equipment/adaptations include:

a. Ramps
b. Lifts/elevators
    1. Porch or stair lifts
    2. Hydraulic, manual or other electronic lifts
c. Modifications/additions of bathroom facilities
    1. Roll-in showers
    2. Sink modifications
    3. Bathtub modifications/grab bars
    4. Toilet modifications/grab bars
    5. Water faucet controls
    6. Floor urinal and bidet adaptations and plumbing modifications
    7. Turnaround space adaptations
d. Widening of doorways/hallways
e. Specialized accessibility/safety adaptations/additions
    1. Door-widening
    2. Electrical wiring
    3. Grab bars and handrails
    4. Automatic door openers/doorbells
    5. Voice activated, light activated, motion activated and electronic devices
    6. Fire safety adaptations
    7. Medically necessary air filtering devices
    8. Medically necessary heating/cooling adaptations
f. Trained and certified canine assistance
    1. Purchase of trained canine
    2. Training for recipient and canine
    3. Animal upkeep (dog food, license, tax, supplies)
    4. Emergency and preventative Veterinarian services
g. Vehicle adaptations
    1. Lifts
    2. Door modifications
    3. Steering/braking/accelerating/shifting modifications
    4. Seating modifications

5. Safety/security modifications

Other adaptation and repairs may be approved on a case-by-case basis as technology changes or as an individual's physical or environmental needs change.

Limitations: Each environmental adaptation must be: 1) documented as medically necessary by a physician; 2) prior approved by DSPD in accordance with written policy including defined qualifying criteria; and 3) documented as not otherwise available as a Medicaid State Plan service. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual. General household repairs are not included but repairs to housing modifications will be allowed, as necessary, if identified in the individual's support plan. These repairs must be limited to the repair of previously approved modifications or adaptations that are directly and exclusively related to allowing the individual to remain in housing within their community and avoid placement in an ICF/MR. All services shall be provided in accordance with applicable State or local building codes.

X **Extended Living Supports**

Supervision, socialization, personal care and supports for persons who reside in a community living setting during the period of time they would normally be attending an employment, day or school program. Extended living supports are intended to be utilized for short periods of time, such as illness, recovery from surgery and/or transition between service providers and are not intended for long term use in lieu of supported employment, day supports or school programs.

Limitations: Individuals receiving Extended Living Supports may not receive Day Supports Services simultaneously. This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Family Training and Preparation Service**

Training and guidance services for covered individuals or family members. For purposes of this service, "family" is defined as the persons who live with or provide care to a individual served under the waiver, and may include a parent, spouse, children, relatives, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home and to maintain the integrity of the family unit. Training may also include instructions on how to access services, how to participate in the self-direction of care, how to hire, fire and evaluate service providers, consumer choices and rights, consumer's personal responsibilities and liabilities when receiving services under the self-administered services method (e.g., billing, reviewing and approving timesheets),

instruction to the family, and skills development training to the individual relating to interventions to cope with problems or unique situations occurring within the family, techniques of behavior support, social skills development, and accessing community cultural and recreational activities.

The Family Training and Preparation Services category may be provided under the Agency-Based Services or the Self-Administered Services method.

Limitations: Services and supports provided through the Family Assistance and Support category are intended to accomplish a clearly defined outcome that is outlined in the individual support plan, including the expected duration of the activity and the measures to be used to gauge progress. The activities will not consist solely of supervision, companionship or observation of the individual during leisure and other community events. Family Training and Preparation services are not available to foster families. This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Family and Individual Training and Preparation Services**

Training and guidance services for covered individual or family member. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, , or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home and to maintain the integrity of the family unit. Training may also include instructions on how to access services, how to participate in the self-direction of care, how to hire, fire and evaluate service providers, consumer choices and rights, consumer's personal responsibilities and liabilities when participating in consumer-directed programs (e.g., billing, reviewing and approving timesheets), instruction to the family, and skills development training to the individual relating to interventions to cope with problems or unique situations occurring within the family, techniques of behavior support, social skills development, and accessing community cultural and recreational activities. Family and Individual Training and Preparation Service is intended for families who present with considerably more complex or dysfunctional issues than those receiving Family Training and Preparation services, and may include families with multiple consumers within the family. Or, families receiving this service have been assessed as requiring a more sophisticated level of training and assistance than those receiving routine Family Training and Preparation services. Services rendered under this service definition are delivered by Bachelors level staff with considerably greater training and experience than those rendering service under the Family Training and Preparation Service definition, including specific topical training in family and individual consultation.

Services may also include those that enhance the individual's ability to exercise individual rights as a member of society through self-sufficiency and informed decision-making. Supports include: (a) Training in conflict resolution and mediation of

disagreements, and forming a consensus (b) Identifying, building, and maintaining natural supports; and, (c) Instructing and consulting with families on ways to become as self-sufficient as possible.

The Family and Individual Training and Preparation Services category may be provided under the Agency-Based Services or the Self-Administered Services method.

Limitations: Services and supports provided through the Family and Individual Training and Preparation Services category are intended to accomplish a clearly defined outcome that is outlined in the individual support plan, including the expected duration of the activity and the measures to be used to gauge progress. The activities will not consist solely of supervision, companionship or observation of the individual during leisure and other community events. Family and Individual Training and Preparation services are not available to foster families. This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Financial Management Services**

This service is offered in support of the self-administered services delivery option. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, (c) Medicaid claims processing and reimbursement distribution, and (d) providing monthly accounting and expense reports to the consumer.

X **Homemaker Services**

Serve the purpose of maintaining a clean and sanitary living environment in the individual's residence.

Homemaker Services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for those activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

The Homemaker Services category may be provided under the Agency-Based Services or the Self-Administered Services method.

Limitations: These services will be provided only in the case where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. Homemaker Services are not available to individuals receiving other waiver services in which the services are essentially duplicative of the tasks defined in Homemaker Services. This service is not available to children in the

custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Living Start-Up Costs**

For individuals transitioning from an ICF/MR or other inpatient medical institution into the community, this service provides reimbursement for the purchase of essential household items needed to establish basic living arrangements that allow the individual to live safely in the community. Essential household items include a bed, a table, chairs, bathroom furnishings, pots, pans, storage containers, utensils, broom, vacuum, plates, dishes, bowls, cups, telephone, answering machine, alarm clocks, hangers, duplicate keys, locks, non-refundable set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating).

Limitations: Reimbursement for the cost of rent or food is not a covered expense under this service. Reimbursable items are limited to only those household items that are essential. Reimbursement for entertainment and diversional items such as televisions, stereos, DVD players, VCR's, CD players, or gaming systems, etc. is prohibited. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.

This service requires prior authorization by a Division of Services for People with Disabilities designee and is only available to those transitioning from an ICF/MR or other inpatient medical institution into the community. This service is available only after attempts to access start-up items from all alternative sources have been exhausted. Efforts to access alternative sources must be documented in the individual's case file. Copies of this documentation must be submitted to the Division of Services for People with Disabilities prior authorization designee for review.

X **Massage Therapy**

Provision of therapeutic services delivered by licensed massage therapists intended to provide comfort, stress and tension relief and reduction, and other health-related benefits consistent with the practice of massage therapy. This service is intended to accomplish a clearly defined outcome that is outlined in the individual support plan.

Limitations:
Message therapy category of service includes both an agency-based provider model and a self-directed services method.

X **Personal Assistance**

Provision of personal assistance and supportive services, specific to the needs of a medically stable, individual who is capable of directing his/her own care or has a surrogate available to direct the care. This service is intended to reinforce an individual's

strengths, while substituting or compensating for the absence, loss, diminution, or impairment of physical or cognitive functions. Services will be outlined in the individual support plan and will not duplicate other covered waiver supports.
Personal assistance services are provided on a regularly scheduled basis and are available to individuals who live alone or with roommates. Services may be provided in the recipient's place of residence or in settings outside the place of residence.

Limitations: Individuals receiving any other service contained within this waiver that may duplicate the provision of Personal Assistance are not eligible to receive Personal Assistance.

X **Personal Budget Assistance**

Personal budget assistance provides assistance with financial matters, fiscal training, supervision of financial resources, , savings, retirement, earnings and funds monitoring, monthly check writing, bank reconciliation, budget management, tax and fiscal record keeping and filing, and fiscal interaction on behalf of the individual.

Personal Budget Assistance is available to those who choose either the Agency-provider method or the Self-Administered Services method.

X **Personal Emergency Response System (PERS) – Installation & Testing /Monthly Fee/Purchase**

Serves the purpose of enabling the individual who has the skills to live independently or with minimal support to summon assistance in case of an emergency.
Personal Emergency Response System is an electronic device of a type that allows the individual requiring such a system to rapidly secure assistance in the event of an emergency. The device may be any one of a number of such devices but must be connected to a signal response center that is staffed twenty-four hours a day, seven days a week by trained professionals.

Elements of Personal Emergency Response System:
Installation and testing of the Personal Emergency Response System;
Monthly Fee is the periodic service fees (e.g., monthly) for ongoing support services and or rental associated with the Personal Emergency Response System; and
Purchase of Personal Emergency Response System.

X **Professional Medication Monitoring**

Medication monitoring, testing and nursing services necessary to provide medication management to assure the health and welfare of the person. This service includes regularly scheduled, periodic visits by a nurse in order to conduct an assessment of the individual with regard to their health and safety particularly as it is affected by the maintenance medication regimen that has been prescribed by their physician, to review and monitor for the presence and timely completion of necessary laboratory testing related to the medication regimen, and to offer patient instruction and education

regarding this medication regimen. Nurses will also provide assistance to the individual by ensuring that all pill-dispensing aids are suitably stocked and refilled.

Limitations: This service is not available to individuals eligible to receive this service through the Medicaid State Plan or other funding source.

X **Residential Habilitation**

Residential habilitation means individually tailored supports that assist with acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Residential Habilitation Settings:

- Group Homes – Licensed facilities in which 4 or more individuals reside
- Supervised Private Residences – Individual supervised apartments or home settings in which 3 individuals or less reside
- Professional Parent Homes – Supervised Private Residences for 2 or less individuals under the age of 22.
- Host Homes – Supervised Private Residences for 2 or less individuals aged 22 or older.

Limitations: Payment is not made for the cost of room and board, the cost of building maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a residence required to assure the health and welfare of residents, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the individual's immediate family. Payment for this service is also unavailable to those who are simultaneously receiving any other services within this waiver that would be duplicative or overlapping in nature of the services contained within this service definition.

This service is available to minors in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services. For children in the custody of the Division of Child and Family Services, the costs of basic and routine support and supervision are not covered as waiver services. Compensation for this routine support and supervision are covered by other funding sources associated with the Division of Child and Family Services. Children in DCFS custody are eligible to receive this service only after the provision of this service has been prior-authorized by the minor's support coordinator. Such prior-authorization will occur only after it has been determined that the minor has exceptional care needs that materially affect the intensity or skill level required of the service provider. Evidence that a minor in custody has such exceptional care needs include any one of the following: emotional or behavioral needs such as hyperactivity; chronic depression or withdrawal; bizarre or severely disturbed behavior; significant acting out behaviors; persistent attempts at elopement; habitual alcohol or drug use;

sexually promiscuous behavior; sexual perpetration; persistent injurious or destructive behaviors; severe eating disorders including anorexia nervosa, pica or polydipsia; the presence of psychotic or delusional thinking and behaviors; or, the minor otherwise demonstrates the need for 24-hour awake supervision or care in order to ensure the safety of the minor and those around him/her. Additionally, minors in custody of the State of Utah: Department of Human Services, Division of Child and Family Services may only receive this service if they demonstrate medical or personal care needs of an exceptional nature including any one of the following: requiring catheterization or ostomy care; requiring tube or gavage feeding or requires supervision during feeding to prevent complications such as choking, aspiration or excess intake; requires frequent care to prevent or remedy serious skin ailments such as pressure sores or persistent wounds; requires suctioning; requires assistance in transferring and positioning throughout the day; require two or more hours of therapy follow-through per day; requires assistance with multiple personal care needs including dressing, bathing and toileting; requires complex medical, medication or treatment follow-through throughout the day; or, the minor has a complex and unstable medical condition that requires constant and direct supervision.

This service is intended to accomplish a clearly defined set of outcomes associated with the child's habilitation that is outlined in their individual support plan. Services provided under this service definition are only those that are over and above the basic routine supports provided for through the Division of Child and Family Services.

X **Respite Care - Routine**

Care provided to give relief to, or during the absence of, the normal care giver. Routine respite care may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility approved by the State which is not a private residence, or in the private residence of the respite care provider.

Respite Care –Routine category includes both an agency-based provider model and a self-directed services method.

Limitations: Payments for respite services are not made for room and board except when provided as a part of respite care in a setting, approved by the State that is not the individual's private residence. In the case of respite care services that are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Out of the home/Room and Board included" billing code.

In the case of services contained within this definition provided in the provider's or the consumer's home, in no case will more than four (4) individuals be served by the provider at any one time, except that the provider's children over the age of 14 will not be counted toward the limit of four. In the case of services included in this definition provided by a facility-based program, no more than twenty (20) individuals will be served by the provider at any one time, conditioned upon the stipulation that the provider deploys sufficient staff to meet staff to client ratios approved by the DSPD Regional Director of the appropriate region in advance and further, that staff to client ratios

maintained by providers of this service fully conform to all relevant specifications in applicable licensing statutes or administrative rule. Individuals receiving services within the Day Supports or Supported Living services may receive Respite Care-Routine services only on an hourly and not a daily basis and only during times that they are not receiving Day Supports or Supported Living services, when the need exists and approval has been granted in advance for the utilization of this service by the appropriate DSPD Region Director. All instances in which Respite Care-Routine services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.

This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.
This service is not for ongoing daycare nor is this service intended to supplant resources otherwise available for child-care.

X **Respite Care – Intensive**

Care provided to give relief to, or during the absence of, the normal caregiver.
Intensive level respite care is provided to individuals who have complex conditions that require a level of assistance beyond that which is offered by direct service staff under the definition of Respite Care-Routine. Individuals receiving Respite Care-Intensive Level services will typically present with a more complex array of physical or behavioral needs than those receiving routine respite care services. Services may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility approved by the State that is not a private residence, or in the private residence of the respite care provider. Respite Care-Intensive level services are, because of their more complex nature, delivered by more experienced and sophisticated staff.

The Respite Care –Intensive Level category includes both an agency-based provider method and a self-administered services method.

Limitations: Payments for respite services are not made for room and board except when provided as a part of respite care in a setting, approved by the State that is not the individual's private residence.In the case of respite care intensive services that are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Intensive-Out of the home/Room and Board included" billing code. All instances in which Respite Care-Intensive services are delivered for a period of six hours or more within a day shall be billed using a daily rate rather than hourly rates for this service.

This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.
This service is not for ongoing daycare nor is this service intended to supplant resources otherwise available for child-care.

X **Respite Care - Weekly**

Care rendered on a weekly basis which is provided to relieve, or during the absence of, the normal care giver which is furnished to a covered individual on a short term basis in a facility or other approved community based entity and is not the covered individual's or immediate family's normal place of residence (i.e. a certified facility, temporary care facility, overnight camp, summer programs or a facility providing group respite).

The Respite Care –Weekly category includes both an agency-based provider method and a self-administered services method.

Limitations:
This service is not available to children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services.

X **Specialized Medical Equipment/Supplies/Assistive Technology –Monthly Fee**

Periodic service (e.g., monthly) fees for ongoing support services and/or rental associated with devices, controls, or appliances, specified in the individual support plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Limitations: Expenditures for specialized medical equipment and supplies will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and medical supplies must be prior approved based on a determination of medical necessity, a determination that the item is not available as a Medicaid State Plan service, and a determination that rental or payment of a monthly fee for equipment or supplies is a more cost effective than purchasing the equipment outright.

X **Specialized Medical Equipment/Supplies/Assistive Technology – Purchase**

The purchase of devices, controls, or appliances, specified in the individual support plan, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical

or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Elements of Specialized Medical Equipment & Supplies Category: The Specialized Medical Equipment & Supplies category includes elements for purchase and for an ongoing service fee.

Limitations: Expenditures for specialized medical equipment and supplies will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each item of specialized medical equipment and medical supplies must be prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

X **Supported Employment**

Serves the purpose of supporting individuals, based on individual need, to obtain, maintain, or advance in competitive employment in integrated work settings.

Supported Employment can be full or part time and occurs in a work setting where the individual works with individuals without disabilities (not including staff or contracted co-workers paid to support the individual). Supported Employment may occur anytime during a twenty-four hour day and supports are made available in such a way as to assist the individual to achieve competitive employment (compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled). Individuals in Supported Employment are supported and employed consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual as indicated in the individual's support plan. An individual may be supported individually or in a group. Supported Employment may also include activities and supports designed to assist individuals who are interested in creating and maintaining their own business enterprises.

Elements of Supported Employment Services Category:
Supported Employment Co-Worker Services – provider contracts with a co-worker to provide additional support under the direction of a job coach as a natural extension of the workday.
Supported Employment Enclave/Mobile Work Crew- A small crew of waiver participants, or enclave are trained and supervised amongst employees who are not disabled at the host company's worksite, or the crew may operate a self-contained business that operates at multiple locations within the community, under the supervision of a job coach.
Supported Employment – Customized Employment – Individuals desiring to create and implement their own business enterprises receive training, instruction and coaching from a provider in such topics as: creating a business plan, conducting a market analysis, obtaining business financing, implementing the business and managing financial accounts.

Limitations: Payment will only be made for adaptations, supervision and training required by an individual as a result of the individual's disability and will not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation will be maintained that supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Act. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as incentive payments made to an employer or beneficiaries to encourage or subsidize an employer's participation in a supported employment program, payments that are passed through to a beneficiary of Supported Employment programs, or for payments for vocational training that is not directly related to a beneficiary's Supported Employment program.

X **Supported Living**

Individually tailored hourly support, supervision, training and assistance for people to live as independently as possible in their own homes, family homes and apartments. Supported living is available to those who live alone, with family or with roommates. For individuals residing with families, Supported Living is intended to provide support to the individual and the family to allow the family to continue providing naturals supports and to avoid unwanted out of home placement. Supported living activities are prioritized based upon the individual's assessed needs, but may include maintenance of individual health and safety, personal care services, homemaker, chore, attendant care, medication observation and recording, advocacy, communication, assistance with activities of daily living, instrumental activities of daily living, transportation to access community activities, shopping and attending doctor appointments, keeping track of money and bills and using the telephone; and indirect services such as socialization, self-help, and adaptive/compensatory skills development necessary to reside successfully in the community. This service may also include behavioral plan implementation by direct care staff.

The Supported Living category is intended for those participating in both the agency-based provider method and the self-administered services method.

Limitations: Individuals receiving Supported Living are not eligible to receive separate individual waiver services in addition to Supported Living if the separate services are essentially duplicative of the tasks defined in Supported Living.

Individuals receiving Supported Living may not receive Residential Habilitation; however, they may receive Day Support Services provided that these services are not provided nor billed for times when the individual is receiving Supported Living services.

X **Transportation – Non-Medical**

Transportation services offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the individual service plan. Individuals receiving services shall be trained, assisted and provided opportunities to use regular transportation services available to the general public in their communities. If regular transportation services are not available or do not meet the needs of the waiver participant, waiver non-medical transportation becomes an option. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Elements of Transportation services Category:

Transportation Services has three component units of service: (a) self-directed services model as a per mile unit, (b) agency based provider model as a daily unit, and (c) multi-pass public transit system model as a per-service unit.

Limitations: Medicaid payment for transportation under the approved waiver plan is not available for medical transportation, transportation available thru the State plan, transportation that is available at no charge, or as part of administrative expenditures. Additionally, this service is not available to children in the custody of the State of Utah:

Department of Human Services, Division of Child and Family Services for the purposes of visitation to a family home.

X **Waiver Support Coordination**

Serves the purpose of maintaining the individual in the Home and Community-Based Services Waiver in accordance with program requirements and the person's assessed service needs, and coordinating the delivery of quality waiver services. Waiver Support Coordination consists of the following activities:

(a) Validate the initial comprehensive assessment and the initial comprehensive service plan for an individual newly enrolled in the waiver program;
(b) Consult the Waiver Eligibility Determination and Enrollment agency to modify the initial comprehensive assessment and service plan as necessary;
(c) Present the individual with choice of services/service providers from which to receive waiver services;
(d) Assist the individual to request a fair hearing if choice of services/service providers is denied;
(e) Perform comprehensive service reassessments and develop updated comprehensive service plans at the intervals specified in appendices D and E;
(f) Monitor on an ongoing basis the individual's health and safety status and initiate appropriate reviews of service needs and service plans as needed;
(g) Coordinate with other Medicaid programs to achieve a holistic approach to service delivery;
(h) Research the availability of non-Medicaid resources needed by the individual to address the assessed needs and assist the individual to gain access to these resources regardless of the funding source;
(i) Assist the individual to gain access to waiver services and Medicaid State Plan services necessary to address the assessed needs;
(j) Monitor to assure the provision and quality of the services identified in the individual's service plan;
(k) Instruct the individual/legal representative/family how to independently obtain access to services when other funding sources are available;
(l) Provide discharge planning services to an individual disenrolling from the waiver to assure and safe and orderly disenrollment.

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensing, Regulation, Utah Code Annotated (UCA), and Utah Administrative Code (UAC) are referenced by citation. Standards not addressed under uniform State citation are attached. Home and community-based waiver services for individuals with Mental Retardation and Other Related Conditions are covered benefits only when delivered through entities contracted with the State Medicaid Agency as evidenced by a signed Medicaid Provider Agreement or a Self-Directed Services Employer-Employee contract.

For purposes of this appendix, the term Individual Medicaid Provider may be an individual Fiscal Agent, professional agency, commercial business, or other organization.

This waiver is operated without a companion Medicaid 1915(b) Freedom of Choice Waiver. All covered waiver services listed in Appendix B-1 may be provided by any willing provider that meets the specified qualifications listed in this Appendix and is enrolled with the Medicaid program to provide the service and receive Medicaid reimbursement.

SERVICE PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Behavior Consultation Services I		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA ❷ Training and experience in the field of mental retardation and other related conditions of at least one year's length; completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course.
Behavior Consultation Services II		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA ❷ Board Certified Associate Behavior Analysts (BCABA); or proof of achievement of a post-graduate degree of at least a Masters' in a behaviorally-related field as well as experience of at least one year working in the field of mental retardation or other related conditions. 3. Completion of a training course in positive behavioral supports prescribed by DSPD and approved by the SMA and the successful completion of a learning assessment at the conclusion of the course.
Behavior Consultation Services III		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA ❷ Board Certified Behavior Analysts (BCBA); or proof of achievement of a post-graduate degree of a doctoral level in a behaviorally related field and a combination of training and experience equivalent to that required for certification as a Board Certified Behavior Analysts.

Chore Services		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Companion Services		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Day Supports – Site and Non-Site Based	Site based: R501-2, UAC R539-6, UAC R539-7, UAC (4 or more individuals)	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Environmental Adaptations -	Current business license.	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Extended Living Supports	R501-2 UAC, R539-6 UAC (4 or more individuals)	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Family Training		Certified by DSPD as an authorized provider of	❶ Under state contract with DSPD as an authorized

and Preparation Services		services and supports to people with disabilities in accordance with 62A-5-103, UCA.	provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Family and Individual Training and Preparation Services-		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ❷ Must complete a training course prescribed by DSPD and approved by the State Medicaid Agency and must demonstrate competency in related topical area(s) of: (1) Self-determination (2) Natural supports, (3) Instruction and/or consultation with families/siblings on: a) Assisting self sufficiency b) Safety ❷ Must be a professional with a bachelor's degree in social or behavioral sciences or a mental health professional with a master's degree in social or behavioral sciences.
Fiscal Management Services	Certified Public Accountant: Sec. 58-26A, UCA, and R156-26A, UAC	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Homemaker Services		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Living Start-up Costs		Certified by DSPD as an authorized provider of services and supports to people with disabilities in	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

		accordance with 62A-5-103, UCA.	
Massage Therapy	Licensed Massage Therapist: Sec. 58-47b, UCA and R156-47b, UAC		❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Personal Assistance		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Personal Budget Assistance		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Personal Emergency Response Systems (PERS) **1. Monthly Fee** **2. Installation** **3. Purchase**	Current business license	FCC registration of equipment placed in individual's home	❶ Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Professional Medication Monitoring	RN and LPN: Sec. 58-31b, UCA and R156-31b UAC		❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.

Residential Habilitation Services	R501-2 UAC, R539-6 UAC (4 or more individuals) Professional Parent: Licensed Child Placing Adoption Agencies R501-7-1, UAC	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Respite Care – Routine	Licensed by the State of Utah as a specific category of facility/agency as follows: ICF/MR: R432-152 or R432-201 UAC Licensed Residential Treatment Programs R501-19, UAC Licensed Residential Support Programs R501-22, UAC Nursing Facility: R432-150, UAC Assisted Living Facility: R432-270, UAC	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Respite Care Intensive	Licensed by the State of Utah as a specific category of facility/agency as follows:	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. Evidence of achievement of a college degree at the Bachelor's level or greater.

	ICF/MR: R432-152 or R432-201 Licensed Residential Treatment Programs R501-19, UAC Licensed Residential Support Programs: R501-22, UAC Nursing Facility: R432-150, UAC Assisted Living Facility: R432-270, UAC	103, UCA.	
Respite Care - Weekly		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Specialized Medical Equipment/ Supplies **Monthly Fee and Purchase**	Current business license		❶ Enrolled with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Supported Employment Services		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Supported Living		Certified by DSPD as an	❶ Under state contract with DSPD as an authorized

		authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.
Transportation Services (Non-medical)	Licensed public transportation carrier or individual with driver's license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA.	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ❷ Driver must possess a current Utah Drivers License and proof of auto liability insurance in amounts required by state law.
Waiver Support Coordination		Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ❷ Qualified Mental Retardation Professional (QMRP) as specified in the job specifications contained within: *Interpretive Guidelines for ICF for Persons with Mental Retardation (W159-W180); Code of Federal Regulations, Centers for Medicare and Medicaid Services, State Operations Manual-Appendix J,* pages 77-87. Qualified support coordinators shall possess at least a Bachelors degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to individuals with mental retardation and other related conditions through a successful completion of a training program approved by the State Medicaid Agency.

APPENDIX B-2 – PROVIDER QUALIFICATIONS

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensing or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the Medicaid Single State Agency, and the licensure and certification chart in B-2 (A) must contain the precise citation indicating where the standards may be found.

For each service for which standards other than, or in addition to, State licensure or certification, are specified in B-2 (A) must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are specified below.

Other Standards:

In accordance with 62A-5-103, UAC, authorized providers of waiver services must be under State contract with DSPD for the provision of services to people with disabilities. A hard copy of the standard contract is retained by the State Medicaid Agency. An electronic copy of the contract can be accessed at:
http://www.hsdspd.utah.gov/contractamendments.htm

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all available waiver service options and qualified providers of each service included in his or her written service plan.

E. ELIGIBILITY DETERMINATION, ENROLLMENT, AND SERVICE PLAN DEVELOPMENT SAFEGUARDS

The State Medicaid Agency will provide safeguards against potential problems that may arise from conflicts of interest related to the proper and efficient operation of the State Medicaid program, proper and efficient operation of the waiver program, and the arrangement for and provision of covered waiver services. The State has established the following safeguards for this waiver:

1. An agency that will perform both eligibility determination and enrollment activities and waiver case management activities must provide the State Medicaid Agency written documentation of controls that will be used to assure that staff

having decision making authority and responsibility for determining applicants eligibility for the waiver program (and other Medicaid programs), waiver enrollees' eligibility for specific services, and applicants/enrollees' choice of participation in the Medicaid nursing facility program or the waiver program do not have overlapping responsibilities for waiver case management activities for the same waiver participants.

2. Provider organizations/individuals enrolled to perform the responsibilities of the Waiver Case Management covered service, as described in Appendix B-1, may not provide other direct waiver services except by special exemption granted by the Medicaid Agency.

APPENDIX B-3: KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

A. KEYS AMENDMENT ASSURANCE

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. APPLICABILITY OF KEYS AMENDMENT STANDARDS

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

_X_ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C-ELIGIBILITY AND POST-ELIGIBILITY

APPENDIX C-1: ELIGIBILITY

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. __X__ Low-income families with children as described in section 1931 of the Social Security Act.

2. __**X**__ SSI recipients (SSI Criteria States and 1634 States).

3. ____ Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. __X__ Optional State supplement recipients.

5. __**X**__ Optional categorically needy aged and disabled who have income at (Check one):

   a. __**X**__ 100% of the Federal poverty level (FPL)

   b. ____% Percent of FPL which is lower than 100%.

6. __**X**__ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

   __**X**__ A. Yes ___ B. No

Check one:

a. **X** The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. ___ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

___ 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2) ___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) ___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) ___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) ___ Aged and disabled who have income at:

a. ___ 100% of the FPL

b. ___% which is lower than 100%.

(6) ___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. **X** Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. __ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

APPENDIX C-2--POST-ELIGIBILITY

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. **X** **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. **435.726**--States that **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. Individual: (Check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5) X Other (specify):
Net income deduction equals 100% FPL. Earned income deduction equals SSI SGA Level.

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.__ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. Spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$ _____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F._**X**_ The amount is determined using the following formula:

A spousal allowance as determined under 1924 (d) of the Act.

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of standard.

E. X The amount is determined using the following formula: A family allowance for each family member as determined under 1924(d)(1)(C) but not to exceed the AFDC need standard for a family of the same size.

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. **X** The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (Check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: ___%

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f) **X** The following formula is used to determine the needs allowance:

Net income deduction equals 100% FPL. Earned income deduction equals SSI SGA Level.

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX C-3: COORDINATION OF MEDICAID ELIGIBILITY DETERMINATION AND LEVEL OF CARE DETERMINATION

Enrollment in the Home and Community-Based waiver is not permitted prior to the date the Medicaid applicant has been determined to meet eligibility for the Medicaid program, the level of care eligibility defined by the Medicaid program for ICF/MR admission, and the additional targeting criteria of Items 3 and 4.

For purposes of the waiver program, documentation of the eligibility dates is accomplished through completion of the Form 927, Home and Community-Based Waiver Referral Form, including signatures by both a Medicaid eligibility worker and by the Support Coordinator. The Form 927 must specify the effective date of applicant's Medicaid eligibility determination and the effective date of the applicant's level of care and targeting criteria eligibility determination and be maintained on file by the appropriate Support Coordinator.

Payment for Home and Community-Based waiver services are not permitted prior to the date the Medicaid applicant has been enrolled into the waiver except in the case of waiver eligibility determination and enrollment services involving discharge and transition planning provided to a ICF/MR resident in the 90-day period immediately preceding his or her first day of admission to the waiver.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1: EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

A. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Social Services Worker, licensed in the State

X* Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
*Qualified Waiver Support Coordinator (see provider qualifications, in Appendix B-2 and B-3).

___ Other (specify):

B. STATE MEDICAID AGENCY OVERSIGHT OF LEVEL OF CARE DETERMINATION

The State Medicaid Agency has an interagency agreement authorizing the Division of Services for People with Disabilities to certify the level of care for waiver applicants and recipients. The DD/MR support coordinator in the Division of Services for People with Disabilities completes the initial level of care determination. However, final responsibility for oversight of the level of care determination process remains with the single state agency and the State Medicaid Agency retains authority to review level of care determinations made by the Division of Services for People with Disabilities and to make necessary modifications to the determinations.

APPENDIX D-2: REEVALUATIONS OF LEVEL OF CARE

A. FREQUENCY OF REEVALUATIONS

Reevaluations of the level of care required by the participant will take place (at a minimum) according by the following schedule (specify):

___ Every 3 months

___ Every 6 months

X Every 12 months * (or more often as needed)

__ Other (specify):

*The Individual's level of care is screened at the time a substantial change in the individual's health status occurs to determine whether the individual's resultant an ongoing need for ICF/MR level of care, this includes at the conclusion of an inpatient stay in a medical institution.

A full level of care reevaluation is conducted whenever indicated by a health status change screening and as a minimum within 12 consecutive months of the last recorded level of care determination.

B. QUALIFICATIONS OF EVALUATORS PERFORMING REEVALUATIONS

Check one:

X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care. (Specify.)

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in Appendix B1 of this document

___ Other (specify):

C. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (check all that apply):

___ "Tickler" files

___ Edits in computer system

_X_ Component part of support coordination

___ Other (specify):

APPENDIX D-3: MAINTENANCE OF RECORDS

A. LOCATION OF RECORDS

1. Record of evaluations and reevaluations of level of care will be maintained in the following locations (check all that apply):

   ___ In the Medicaid agency in its central office

   ___ In the Medicaid agency in district/local offices

   X In the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

   X In the support coordinator's files for the individuals

   ___ In the files of the person(s) or agencies designated as responsible for the performance of evaluations and reevaluations

   ___ By service providers

   ___ Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this appendix for a minimum period of 3 years.

B. COPIES OF CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument, Form 817, used in the evaluation and reevaluation of a recipient's need for a level of care is attached to this Appendix (see pages_____).

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

X The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals

C. DOCUMENTATION REQUIRED TO MAKE A LEVEL OF CARE DETERMINATION

The following histories/evaluations are required for determination of level of care:

1. Assessments of functional limitations in the areas of self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

2. Social History and/or Social Summary - completed by applicant or for the applicant no longer than one year prior to the date of application.

3. Psychological or Special Education Evaluation completed no longer than 5 years prior to the date of original waiver eligibility determination.

4. Medical Nursing Evaluation – completed by a physician or registered nurse no longer than one year prior to the date of original eligibility determination – this form is only required for cases in which the personperson has specific medical conditions that are complex and/or may require additional services to meet the individual's specific medical needs.

5. Documentation of date of onset of disability.

D. LEVEL OF CARE EVALUATION QUALITY ASSURANCE

The State Medicaid Agency retains final authority for oversight of the level of care evaluation process as set forth in Section IV-G of the interagency agreement between the State Medicaid Agency and the Department of Human Services. The oversight function involves an annual review of the level of care evaluations for a sample of waiver participants representative of the caseload distribution across the program. If the sampling identifies potential level of care systematic problems, an expanded review is initiated by the State Medicaid Agency.

APPENDIX D-4: FREEDOM OF CHOICE AND FAIR HEARING

A. FREEDOM OF CHOICE OF MEDICAID LTC PROGRAM

1. The agency evaluates whether the individual will likely require the ICF/MR level of care and the individual's general LTC needs and provides information to the individual about the types of services available through the waiver and through the Medicaid ICF/MR as part of an intake and screening process.

2. When an individual is determined to be likely to require the level of care specified for this request, the person or the person's legal representative will be:

    a. Informed of any feasible alternatives under the waiver; and

    b. Given the choice of either institutional or home and community-based services.

3. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care specified for this request, or who are denied the waiver service(s) of their choice or the waiver provider(s) of their choice.

4. The following are attached to this Appendix:

    a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

    b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

    c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

    d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

B. FREEDOM OF CHOICE DOCUMENTATION

Freedom of choice is documented on the Form 817 (Page D-15) and is maintained in the support coordinator's file for the individual.

Freedom of choice procedures

1. When an individual is determined eligible for waiver services, the individual and the individual's legal representative if applicable, will be informed of the alternatives available under the waiver and offered the choice of institutional care (ICF/MR) or home and community-based waiver services. A copy of the DSPD publication *A GUIDE TO SERVICES FOR PEOPLE WITH DISABILITIES* (hereafter referred to as the Guide), which describes the array of services and supports available in Utah including ICF's/MR and the HCBS Waiver program, is given to each individual making application for waiver services.

2. The support coordinator will offer the choice of waiver services only if:

    a. The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community.

    b. All parties have agreed to the individual support plan.

    c. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.

3. Once the individual has chosen home and community-based waiver services, the choice has been documented by the support coordinator, and the individual has received a copy of the Guide, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the individual support plan. It is, however, the individual's option to choose institutional (ICF/MR) care at any time during the period they are in the waiver.

4. The waiver enrollee, and the individual's legal representative if applicable, will be given the opportunity to choose the providers of waiver services identified on the individual support plan if more than one qualified provider is available to render the services. The individual's choice of providers will be documented in the individual's support plan.

C. RIGHTS TO A FAIR HEARING DOCUMENTATION

1. DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

An individual and the individual's legal representative will receive a written Notice of Agency Action from the waiver support coordinator if the individual is not given the choice of home and community-based services as an alternative to institutional care, or who is denied the waiver service(s) of their choice, or the provider(s) of their choice, or who is found ineligible for the waiver program.

The Notice of Agency Action delineates the individual's right to appeal the decision. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

The waiver individual support plan serves as the formal document identifying services that the waiver enrollee receives based on the comprehensive needs assessment. At the time a substantial change in a waiver enrollee's condition results in a change in the person's assessed needs, the individual support plan is revised to reflect the types and levels of service necessary to address the current needs. If the revisions to the individual support plan result in termination of a covered waiver service, reduction in the waiver services being received, or denial of services that the individual feels are necessary to prevent institutionalization, the individual or legal representative has the right to appeal the decision to revise the individual support plan. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

2. SINGLE STATE AGENCY

The State Medicaid Agency provides individuals applying for or receiving waiver services an opportunity for a hearing upon written request (see A.1. above), if they are:

a. Not given the choice of institutional (NF) care or community-based (waiver) services;

b. Denied the waiver provider(s) of their choice if more than one provider is available to render the service(s);

c. Denied access to waiver services identified as necessary to prevent institutionalization; or

d. Experience a reduction, suspension, or termination in waiver services identified as necessary to prevent institutionalization.

It is the policy and preference of the single State agency to resolve disputes at the lowest level through open discussion and negotiation between the involved parties.

DIVISION OF HEALTH CARE FINANCING
ADMINISTRATIVE HEARING PROCEDURES

All hearings before the Division of Health Care Financing except as otherwise set forth shall be conducted as a formal hearing.

Advance Notice

1. Each individual who is affected by an adverse action taken by DHCF or its administrative Fiscal Agent will be given advance notice of such action:

2. A notice must contain:

    a. A statement of the action DHCF or its administrative Fiscal Agent intends to take;
    b. The date the intended action takes effect;
    c. The reasons for the intended action;
    d. The aggrieved person's right to request a formal hearing before DHCF, when applicable, and the method by which such hearing may be obtained from DHCF;
    e. A statement that the aggrieved person may represent himself or use legal counsel, relative, friend, or other spokesman at the formal hearing; and,
    f. An explanation of the circumstances under which Medicaid coverage or reimbursement will be continued if a formal hearing is timely requested.
    g. DHCF will mail an advance notice at least ten calendar days before the date of the intended action.

Request for Formal Hearing

1. An aggrieved Medicaid applicant/recipient/provider may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or inaction.

2. Failure to submit a timely request for a formal hearing will constitute a waiver of a person's formal hearing or pre-hearing rights. A request for a hearing shall be in writing, shall be dated, and shall explain the reasons for which the hearing is requested.

3. The address for submitting a "Request for Hearing/Agency Action" is as follows:

Division of Health Care Financing
Attention: Formal Hearings
P.O. Box 16580
Salt Lake City, UT 84116-0580

Reinstatement/Continuation of Services

1. DHCF may reinstate services for recipients or suspend any adverse action for recipients/providers if an aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.

2. DHCF must reinstate or continue services for recipients or suspend adverse actions for providers until a decision is rendered after a formal hearing if:

    a. Adverse action is taken without giving the ten-day advanced mailed notice to a recipient/provider in all circumstances where such advance notice is required;

    b. In those circumstances where advance notice is not required, the aggrieved person requests a formal hearing within ten calendar days following the date the adverse action notice is mailed; or

    c. DHCF determines that the action resulted from other than the application of federal or state law or policy.

APPENDIX D-5: REVIEW PROTOCOLS FOR WAIVER DISENROLLMENT

The Division of Health Care Financing (DHCF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

1. Voluntary disenrollments are cases in which participants choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. The Division of Services for People with Disabilities will maintain documentation detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.

2. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:

    a. Participant death;

    b. Participant no longer meets financial requirement for Medicaid program eligibility;

    c. Participant has moved out of the State of Utah; or

    d. Participant whereabouts are unknown.

3. Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. The Division of Services for People with Disabilities will maintain documentation detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.

4. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver participants no longer meets the corresponding institutional level of care requirements, the participants health and safety needs cannot be met by the current program's services and supports, or the participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a individual support plan that meets minimal safety standards.

5. Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

    a. Appropriate movement amongst programs;

    b. Effective utilization of program potential;

    c. Effective discharge and transition planning;

    d. Provision of information, affording participants the opportunity to exercise all rights; and

    e. Program quality assurance/quality improvement measures.

6. The special circumstance disenrollment review process will consist of the following activities:

    a. The waiver support coordination agency recommending disenrollment will compile information to articulate the disenrollment rationale.

    b. The waiver support coordination agency will then submit the information to the state-level program management staff for their review of the documentation of support coordination activities and of the disenrollment recommendation.

    c. If state-level program management staff concurs with the support coordination recommendation, the case will be forwarded to the DHCF for a final decision.

    d. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

    e. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

f. The DHCF final disenrollment decision will be communicated to both the support coordination agency and the state-level program management staff in writing.

7. If the disenrollment is approved, the waiver support coordination agency will provide to the individual the required written notification of agency action and right to fair hearing information.

8. The support coordination agency will initiate discharge-planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

APPENDIX E – INDIVIDUAL SUPPORT PLAN

APPENDIX E-1: INDIVIDUAL SUPPORT PLAN DEVELOPMENT

1. The following individuals are responsible for the preparation of the individual support plans:

   _____ Registered nurse, licensed to practice in the State

   _____ Licensed practical or Vocational nurse, acting within the scope of practice under State law

   _____ Physician (M.D. or D.O.) licensed to practice in the State

   _____ Social Worker (qualifications attached to this Appendix)

   _____ Support coordination Team consisting of Registered Nurse and Social Services Worker

   X Other (specify):

   Support Coordinator

2. Copies of written individual support plans will be maintained for a minimum period of 3 years. Specify each location where copies of the care plans will be maintained.

   _____ At the Medicaid agency central office

   _____ At the Medicaid agency county/regional offices

   X By the Support Coordinators

   _____ By the agency specified in Appendix A

   _____ Other (specify):

3. The individual support plan is the fundamental tool by which the State will ensure the health and welfare of the participants. As such it will be subject to periodic review and update. The individual support plan development and ongoing review will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the participant's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

_____ Every 6 months

_____ Every 12 months

__X__ Other (specify):

1. The individual support plan should be reviewed and revised as frequently as necessary, with a formal review at least annually, completed during the calendar month in which it is due.

APPENDIX E-2: MEDICAID AGENCY APPROVAL

A. INDIVIDUAL SUPPORT PLAN DEVELOPMENT

The following is a description of the process by which the individual support plan is made subject to the approval of the Medicaid agency:

1. A written individual support plan is developed for each individual who receives Home and Community-Based waiver supports. The support plan describes the type, amount, frequency and duration of services to be furnished and the type of provider who will furnish them. The support plan is developed by the support coordinator in consultation with the individual, the individual's legal representative and others as necessary and appropriate. The support plan constitutes a plan for services, supports and life activities to meet the needs of the individual and prevent institutionalization.

   During the preparation of the written support plan, the individual will be informed in writing of waiver service options available to address the identified needs and of service provider options available for each selected waiver service listed on the written support plan. The individual will be given a choice of available waiver services and waiver service providers.

   The State utilizes the Individual Support Plan (ISP) as a means of identifying the assessed needs of the participant and of identifying the array of services that will meet the participants' assessed needs to achieve the desired outcomes.

   Annual individual budgets are then produced, with sufficient funds allocated to cover the array of services indicated in the ISP. The ISP and the budgets are

reviewed and agreed upon by the individual and the support coordinator. The ISP and the budget are changed during the course of the year, as needed, to address participants' changing needs.

The support coordinator and participant then coordinate on an on-going basis throughout the year to review the progress toward the desired intended outcomes, service utilization and ongoing appropriateness of current services, and budget expenditures.

This ongoing coordination may lead to service utilization patterns that change from one month to the next. This flexibility allows the individual to utilize services in a way that best meets their needs and that is responsive to consumer choice and fluctuations that occur in service need.

Participants may utilize more services in some months than others, but the array of services identified on the ISP, as a whole, remain at or less than the participants annual budget allocation.

2. The DSPD State Office, through an interagency agreement with the State Medicaid Agency, is delegated first level responsibility to review and approve written support plans as part of its state monitoring responsibility.

3. The State Medicaid Agency retains final authority for oversight and approval of the support planning process as set forth in Section G of the interagency agreement between the State Medicaid Agency and DSPD. The oversight function involves an annual review of a sample of waiver recipient's support plans that is representative of the caseload distribution across the program. If the sampling identifies potential support planning systematic problems, an expanded review is initiated by the State Medicaid Agency.

B. STATUTORY REQUIREMENTS AND COPY OF INDIVIDUAL SUPPORT PLAN

1. The support plan will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service regardless of funding source.

2. Additional mandatory support plan content elements are:

    a. Effective date;

    b. Name of individual receiving waiver services;

    c. Address;

    d. Support Coordinator's name and office location;

e. List of all waiver supports to be provided to the individual, including support coordination when applicable, and all other services needed by the individual, regardless of funding source;

f. Documentation of individual's choice of waiver providers and that the individual was advised of hearing rights, if not provided choice;

g. Documentation that individual was informed of rights in accordance with Division of Services for People with Disabilities policies per R539-2-1 and R539-2-5 and rights to hearing;

h. Expected start date, amount, frequency and duration of each support;

i. The type of provider who will furnish each support;

j. Required experience and skills of individual providers of specified Specialized Support(s); Signatures of individual receiving supports, individual's Support Coordinator, and the individual's legal representative (when applicable);

k. Documentation of the individual's choice of waiver services and waiver providers.

3. The *Division of Services for People with Disabilities Service Plan* serves as the standard individual support plan instrument. A copy of the instrument is on file at the State Medicaid Agency.

C. SUPPORT COORDINATION ENCOUNTERS

To better focus primary attention on providing the specific level of support coordination intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual service plan will be the vehicle through which the level of assessed need for case management/support coordination will be detailed in terms of the objectives to be achieved, and the scope, duration, and frequency of intervention to be provided to meet the stated objectives. This approach will also promote case managers/support coordinators having specific information about their expected roles and responsibilities on an individualized waiver personperson basis. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management/support coordination services, and the ongoing evaluation of progress toward the stated objectives.

APPENDIX F - AUDIT TRAIL

A. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

   ____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

   ____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payment are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   ____ Other (Describe in detail):

B. BILLING PROCESS AND RECORDS RETENTION

1. Following on pages F-3 and F-4 is a description of the billing process used for this waiver. Included is a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

    a. When the personwas eligible for Medicaid waiver payment on the data of service;

    b. When the service was included in the approved support plan;

    c. In the case of supported employment or education services included as part of support services, when the personperson was eligible to receive the services, and the services are not available to the person through a program funded under section(s)(15) and (17) of the Individuals with Disabilities Education Act (IDEA) or section 110 of the Rehabilitation Act of 1973.

        X Yes.

        ___ No. These services are not included in the waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

    X All claims are processed through an approved MMIS.

    ___ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A, and providers of waiver services for a minimum period of 3 years.

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. A participant's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. PACMIS interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the participant is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted in accordance with the procedures outlined in Appendix E-2. The Medicaid agency reviews a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.

3. Prior to the delivery of Medicaid reimbursed supported employment services, the Division of Rehabilitation Services (DRS) must document the individual's ineligibility for DRS services funded under section 110 of the Rehabilitation Act. The support coordinator will obtain written documentation (FORM 58) of the DRS determination prior to authorizing reimbursement for supported employment services under the waiver.

   Prior to the delivery of Medicaid reimbursed educational services, the waiver support coordinator must obtain written documentation that the services are not available to the individual through a program funded under section(s) (16) or (17) of the Individuals with Disabilities Education Act (IDEA) The support coordinator will obtain such documentation prior to authorizing Medicaid reimbursement for educational services under the waiver. (This requirement does not pertain to individuals over the age of 22 who are receiving educational services under the waiver.)

4. Prior to the order and delivery of Medicaid reimbursed approved specialized medical equipment, medical supplies, or assistive technology, the support coordinator must obtain prior approval based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1: COMPOSITE OVERVIEW

A. COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: **ICF/MR**

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1 (FY06)	$27,712	$5,741	$66,003	$7,652
2 (FY07)	$28,288	$5,856	$67,323	$7,805
3 (FY08)	$28,853	$5,973	$68,669	$7,961
4 (FY09	$29,428	$6,092	$70,042	$8,120
5 (FY10)	$30,020	$6,214	$71,443	$8,282

B. FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	4050
2	4050
3	4050
4	4050
5	4050

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2: FACTOR D

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2: FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year: 1 X 2 ___ 3 ___ 4 ___ 5 ____
(FY06)

WAIVER SERVICE COLUMN A	TYPE of UNIT	#Unduplicated Users COLUMN B	Avg. # Annual Unit/User COLUMN C	Avg. Unit Cost $ COLUMN D	TOTAL $ COLUMN E
Behavior Consultation Services I	15 minute	175	160	4.88	136,640
Behavior Consultation Services II	15 minute	50	160	8.50	68,000
Behavior Consultation Services III	15 minute	5	160	15.51	12,408
Chore Services	15 minute	124	648	2.93	235,431
Companion Services	Daily[1]	4	62	70.57	17,501
Companion Services	15 minute	6	3552	3.04	64,788
Day Supports (site/non-site)- Hourly	15 minute	88	2020	2.68	476,397
Day Supports (site/non-site) - Daily	Daily[1]	1564	195	48.93	14,922,671
Environmental Adaptations (home)	per episode	29	1	1,792.00	51,968
Environmental Adaptations (vehicle)	per episode	8	1	1,482.00	11,856
Extended Living Supports	15 minute	466	1416	3.34	2,203,919
Family Training and Preparation	15 minute	54	108	2.78	16,213
Family and Individual Training and Preparation	15 minute	77	56	4.88	21,043
Financial Management Services – Low Tier	Monthly	739	12	28.12	249,368
Financial Management Services – High Tier	Monthly	135	12	91.96	148,975
Homemaker	15 minute	10	116	2.98	3,457

Services					
Living Start-up Costs	**per episode**	**15**	**1**	**728.00**	**10,920**
Massage Therapy	**15 minute**	**70**	**12**	**12.80**	**10,752**
Personal Assistance	**15 minute**	**15**	**708**	**2.81**	**29,842**
Personal Budget Assistance	**15 minute**	**200**	**336**	**4.63**	**311,136**
Personal Budget Assistance	**Daily[2]**	**1414**	**94**	**10.04**	**1,334,477**
Personal Emergency Response System – monthly	**monthly**	**49**	**12**	**27.57**	**16,211**
Personal Emergency Response System – installation	**per episode**	**45**	**1**	**52.00**	**2,340**
Personal Emergency Response System – purchase	**per episode**	**45**	**1**	**235.04**	**10,577**
Professional Medication Monitoring	**per episode**	**200**	**12**	**37.44**	**89,856**
Residential Habilitation-facility based	**Daily[1]**	**1214**	**335**	**134.96**	**54,886,882**
Residential Habilitation-Professional Parent/Host Home	**Daily[1]**	**131**	**319**	**102.06**	**4,262,985**
Residential Habilitation-Professional Parent-DCFS	**Daily[1]**	**92**	**319**	**90.85**	**2,666,266**
Respite Care	**Daily[1]**	**679**	**31**	**55.61**	**1,170,535**
Respite Care	**15 minute**	**959**	**1124**	**2.35**	**2,533,103**
Respite Care-Out of home/R&B Inc.	**Daily[1]**	**10**	**31**	**76.60**	**23,746**
Respite Care – Intensive	**15 minute**	**20**	**680**	**4.88**	**66,368**
Respite Care – Intensive	**Daily[1]**	**10**	**20**	**78.08**	**15,616**
Respite Care-Intensive-Out of home/R&B included	**Daily[1]**	**10**	**20**	**96.90**	**19,380**
Respite Care – Weekly	**per session**	**168**	**12**	**90.56**	**182,569**
Specialized Medical Equipment & Supplies - monthly	**monthly**	**15**	**12**	**156**	**28,080**
Specialized Medical Equipment & Supplies – purchase	**per episode**	**87**	**1**	**623.77**	**54,268**
Supported	**15 minute**	**525**	**1120**	**6.13**	**3,604,440**

Employment					
Supported Employment	**Daily[1]**	**272**	**204**	**32.04**	**1,777,836**
Supported Living	**15 minute**	**1200**	**1350**	**4.63**	**7,500,600**
Transportation - mileage	**per mile**	**37**	**1,991**	**.32**	**23,573**
Transportation – daily	**Daily[3]**	**1,658**	**181**	**7.78**	**2,334,762**
Transportation – bus pass purchase	**per episode**	**118**	**6**	**69.00**	**48,852**
Waiver Support Coordination	**monthly**	**4050**	**12**	**217.67**	**10,578,762**
GRAND TOTAL (Sum of Column E)					**112,235,369**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS					**4050**
FACTOR D (Divide Grand Total by Number of Unduplicated Recipients					**27,712**

Notes:

1 All daily rates are based on services rendered for six hours or more per day. (Except Personal Budget Assistance and Transportation))
2 Personal Budget Assistance is a single episode of service
3 Transportation-daily represents the daily rendering of transportation svcs.

APPENDIX G-2: FACTOR D

LOC: ICF/MR

Waiver Year: 1 ____ 2 __X__ 3 ____ 4 ____ 5 _____
(FY07)

WAIVER SERVICE COLUMN A	TYPE of UNIT	#Unduplicated Users COLUMN B	Avg. # Annual Unit/User COLUMN C	Avg. Unit Cost $ COLUMN D	TOTAL $ COLUMN E
Behavior Consultation Services I	**15 minute**	**175**	**160**	**4.98**	**139,440**
Behavior Consultation Services II	**15 minute**	**50**	**160**	**8.67**	**69,360**
Behavior Consultation Services III	**15 minute**	**5**	**160**	**15.82**	**12,656**
Chore Services	**15 minute**	**124**	**648**	**2.99**	**240,252**
Companion Services	**Daily[1]**	**4**	**62**	**71.98**	**17,851**
Companion Services	**15 minute**	**6**	**3552**	**3.10**	**66,067**
Day Supports (site/non-site)-Hourly	**15 minute**	**88**	**2020**	**2.73**	**485,285**
Day Supports (site/non-site) -Daily	**Daily[1]**	**1564**	**195**	**49.91**	**15,221,552**
Environmental Adaptations (home)	**per episode**	**29**	**1**	**1827.84**	**53,007**
Environmental Adaptations (vehicle)	**per episode**	**8**	**1**	**1511.64**	**12,093**
Extended Living Supports	**15 minute**	**466**	**1416**	**3.41**	**2,250,109**
Family Training and	**15 minute**	**54**	**108**	**2.84**	**16,563**

Preparation					
Family and Individual Training and Preparation	**15 minute**	**77**	**56**	**4.98**	**21,474**
Financial Management Services - Low Tier	**Monthly**	**739**	**12**	**28.69**	**254,423**
Financial Management Services – High Tier	**Monthly**	**135**	**12**	**93.84**	**152,021**
Homemaker Services	**15 minute**	**10**	**116**	**3.04**	**3,526**
Living Start-up Costs	**per episode**	**15**	**1**	**742.56**	**11,138**
Massage Therapy	**15 minute**	**70**	**12**	**13.06**	**10,970**
Personal Assistance	**15 minute**	**15**	**708**	**2.87**	**30,479**
Personal Budget Assistance	**15 minute**	**200**	**336**	**4.72**	**317,184**
Personal Budget Assistance	**Daily[2]**	**1414**	**94**	**10.24**	**1,361,060**
Personal Emergency Response System – monthly	**monthly**	**49**	**12**	**28.12**	**16,535**
Personal Emergency Response System – installation	**per episode**	**45**	**1**	**53.04**	**2,387**
Personal Emergency Response System – purchase	**per episode**	**45**	**1**	**239.74**	**10,788**
Professional Medication Monitoring	**per episode**	**200**	**12**	**38.19**	**91,656**
Residential Habilitation-facility based	**Daily[1]**	**1214**	**335**	**137.66**	**55,984,945**
Residential Habilitation-Professional Parent/Host Home	**Daily[1]**	**131**	**319**	**106.11**	**4,434,231**
Residential Habilitation-Professional Parent-DCFS	**Daily[1]**	**92**	**319**	**92.67**	**2,719,679**
Respite Care	**Daily[1]**	**679**	**31**	**56.72**	**1,193,899**
Respite Care-Out of home/R&B included	**Daily[1]**	**10**	**31**	**78.13**	**24,220**
Respite Care	**15 minute**	**959**	**1124**	**2.40**	**2,586,998**
Respite Care – Intensive	**15 minute**	**20**	**680**	**4.98**	**67,728**
Respite Care – Intensive	**Daily[1]**	**10**	**20**	**79.64**	**15,928**
Respite Care-Intensive-Out of home/R&B included	**Daily[1]**	**10**	**20**	**98.84**	**19,768**
Respite Care – Weekly	**per session**	**168**	**12**	**92.37**	**186,218**
Specialized Medical Equipment & Supplies - monthly	**monthly**	**15**	**12**	**159.12**	**28,642**
Specialized Medical Equipment &	**per episode**	**87**	**1**	**636.25**	**55,354**

Supplies – purchase					
Supported Employment	**15 minute**	**525**	**1120**	**6.25**	**3,675,000**
Supported Employment	**Daily[1]**	**272**	**204**	**32.68**	**1,813,348**
Supported Living	**15 minute**	**1200**	**1350**	**4.72**	**7,646,400**
Transportation - mileage	**per mile**	**37**	**1,991**	**0.33**	**24,310**
Transportation – daily	**Daily[3]**	**1,658**	**181**	**7.94**	**2,382,778**
Transportation – bus pass purchase	**per episode**	**118**	**6**	**70.38**	**49,829**
Waiver Support Coordination	**monthly**	**4050**	**12**	**222.02**	**10,790,172**
GRAND TOTAL (Sum of Column E)					**114,567,323**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS					**4050**
FACTOR D (Divide Grand Total by Number of Unduplicated Recipients					**28,288**

Notes:

1All daily rates are based on services rendered for six hours or more per day. (Except Personal Budget Assistance)
2 Personal Budget Assistance is a single episode of service
3 Transportation-daily represents the daily rendering of transportation svcs.

APPENDIX G-2: FACTOR D

APPENDIX G-2 FACTOR D:

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 X 4 ____ 5 ____
(FY08)

WAIVER SERVICE COLUMN A	TYPE of UNIT	#Unduplicated Users COLUMN B	Avg. # Annual Unit/User COLUMN C	Avg. Unit Cost $ COLUMN D	TOTAL $ COLUMN E
Behavior Consultation Services I	**15 minute**	**175**	**160**	**5.08**	**142,240**
Behavior Consultation Services II	**15 minute**	**50**	**160**	**8.84**	**70,720**
Behavior Consultation Services III	**15 minute**	**5**	**160**	**16.14**	**12,912**
Chore Services	**15 minute**	**124**	**648**	**3.05**	**245,074**
Companion Services	**Daily[1]**	**4**	**62**	**73.42**	**18,208**
Companion Services	**15 minute**	**6**	**3552**	**3.16**	**67,346**
Day Supports (site/non-site)-Hourly	**15 minute**	**88**	**2020**	**2.79**	**495,950**
Day Supports (site/non-site) -Daily	**Daily[1]**	**1564**	**195**	**50.91**	**15,526,532**

Environmental Adaptations (home)	**per episode**	**29**	**1**	**1864.40**	**54,068**
Environmental Adaptations (vehicle)	**per episode**	**8**	**1**	**1541.87**	**12,335**
Extended Living Supports	**15 minute**	**466**	**1416**	**3.47**	**2,289,700**
Family Training and Preparation	**15 minute**	**54**	**108**	**2.89**	**16,854**
Family and Individual Training and Preparation	**15 minute**	**77**	**56**	**5.08**	**21,905**
Financial Management Services – Low Tier	**Monthly**	**739**	**12**	**29.28**	**259,655**
Financial Management Services – High Tier	**Monthly**	**135**	**12**	**95.76**	**155,131**
Homemaker Services	**15 minute**	**10**	**116**	**3.10**	**3,596**
Living Start-up Costs	**per episode**	**15**	**1**	**757.41**	**11,361**
Massage Therapy	**15 minute**	**70**	**12**	**13.32**	**11,189**
Personal Assistance	**15 minute**	**15**	**708**	**2.92**	**31,010**
Personal Budget Assistance	**15 minute**	**200**	**336**	**4.82**	**323,904**
Personal Budget Assistance	**Daily[2]**	**1414**	**94**	**10.45**	**1,388,972**
Personal Emergency Response System – monthly	**monthly**	**49**	**12**	**28.68**	**16,864**
Personal Emergency Response System – installation	**per episode**	**45**	**1**	**54.10**	**2,435**
Personal Emergency Response System – purchase	**per episode**	**45**	**1**	**244.54**	**11,004**
Professional Medication Monitoring	**per episode**	**200**	**12**	**38.95**	**93,480**
Residential Habilitation-facility based	**Daily[1]**	**1214**	**335**	**140.41**	**57,103,343**
Residential Habilitation-Professional Parent/Host Home	**Daily[1]**	**131**	**319**	**108.24**	**4,523,241**
Residential Habilitation-Professional Parent-DCFS	**Daily[1]**	**92**	**319**	**94.53**	**2,774,266**
Respite Care	**Daily[1]**	**679**	**31**	**57.86**	**1,217,895**
Respite Care-Out of home/R&B included	**Daily[1]**	**10**	**31**	**79.70**	**24,707**
Respite Care	**15 minute**	**959**	**1124**	**2.44**	**2,630,115**
Respite Care – Intensive	**15 minute**	**20**	**680**	**5.08**	**69,088**
Respite Care – Intensive	**Daily[1]**	**10**	**20**	**81.23**	**16,246**
Respite Care-Intensive-Out of home/R&B included	**Daily[1]**	**10**	**20**	**100.82**	**20,164**
Respite Care – Weekly	**per session**	**168**	**12**	**94.22**	**189,948**
Specialized Medical Equipment & Supplies - monthly	**monthly**	**15**	**12**	**162.30**	**29,214**
Specialized Medical Equipment & Supplies – purchase	**per episode**	**87**	**1**	**648.97**	**56,460**

Supported Employment	**15 minute**	**525**	**1120**	**6.38**	**3,751,440**
Supported Employment	**Daily[1]**	**272**	**204**	**33.33**	**1,849,415**
Supported Living	**15 minute**	**1200**	**1350**	**4.82**	**7,808,400**
Transportation - mileage	**per mile**	**37**	**1,991**	**0.33**	**24,310**
Transportation – daily	**Daily[3]**	**1,658**	**181**	**8.09**	**2,427,793**
Transportation – bus pass purchase	**per episode**	**118**	**6**	**71.79**	**50,827**
Waiver Support Coordination	**monthly**	**4050**	**12**	**226.46**	**11,005,956**
GRAND TOTAL (Sum of Column E)					**116,855,273**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS					**4050**
FACTOR D (Divide Grand Total by Number of Unduplicated Recipients					**28,853**

Notes:

1 All daily rates are based on services rendered for six hours or more per day (except Personal Budget Assistance)

2 Personal Budget Assistance is a single episode of service

3 Transportation-daily represents the daily rendering of transportation svcs.

APPENDIX G-2: FACTOR D

APPENDIX G-2: FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 ____ 4 X 5 ____

(FY09)

WAIVER SERVICE COLUMN A	TYPE of UNIT	#Unduplicated Users COLUMN B	Avg. # Annual Unit/User COLUMN C	Avg. Unit Cost $ COLUMN D	TOTAL $ COLUMN E
Behavior Consultation Services I	**15 minute**	**175**	**160**	**5.18**	**145,040**
Behavior Consultation Services II	**15 minute**	**50**	**160**	**9.02**	**72,160**
Behavior Consultation Services III	**15 minute**	**5**	**160**	**16.46**	**13,168**
Chore Services	**15 minute**	**124**	**648**	**3.11**	**249,895**
Companion Services	**Daily[1]**	**4**	**62**	**74.89**	**18,573**
Companion Services	**15 minute**	**6**	**3552**	**3.23**	**68,838**
Day Supports (site/non-site)-Hourly	**15 minute**	**88**	**2020**	**2.84**	**504,838**
Day Supports (site/non-site) - Daily	**Daily[1]**	**1564**	**195**	**51.92**	**15,834,562**
Environmental Adaptations (home)	**per episode**	**29**	**1**	**1901.68**	**55,149**

Environmental Adaptations (vehicle)	**per episode**	**8**	**1**	**1572.71**	**12,582**
Extended Living Supports	**15 minute**	**466**	**1416**	**3.54**	**2,335,890**
Family Training and Preparation	**15 minute**	**54**	**108**	**2.95**	**17,204**
Family and Individual Training and Preparation	**15 minute**	**77**	**56**	**5.18**	**22,336**
Financial Management Services – Low Tier	**monthly**	**739**	**12**	**29.88**	**264,976**
Financial Management Services – High Tier	**monthly**	**135**	**12**	**97.71**	**158,290**
Homemaker Services	**15 minute**	**10**	**116**	**3.16**	**3,666**
Living Start-up Costs	**per episode**	**15**	**1**	**772.56**	**11,588**
Massage Therapy	**15 minute**	**70**	**12**	**13.58**	**11,407**
Personal Assistance	**15 minute**	**15**	**708**	**2.98**	**31,648**
Personal Budget Assistance	**15 minute**	**200**	**336**	**4.91**	**329,952**
Personal Budget Assistance	**Daily[2]**	**1414**	**94**	**10.65**	**1,415,555**
Personal Emergency Response System – monthly	**monthly**	**49**	**12**	**29.26**	**17,205**
Personal Emergency Response System – installation	**per episode**	**45**	**1**	**55.18**	**2,483**
Personal Emergency Response System – purchase	**per episode**	**45**	**1**	**249.43**	**11,224**
Professional Medication Monitoring	**per episode**	**200**	**12**	**39.73**	**95,352**
Residential Habilitation-facility based	**Daily[1]**	**1214**	**335**	**143.22**	**58,246,142**
Residential Habilitation-Professional Parent/Host Home	**Daily[1]**	**131**	**319**	**110.41**	**4,613,923**
Residential Habilitation-Professional Parent-DCFS	**Daily[1]**	**92**	**319**	**96.42**	**2,829,734**
Respite Care	**Daily[1]**	**679**	**31**	**59.01**	**1,242,101**
Respite Care-Out of home/R&B included	**Daily[1]**	**10**	**31**	**81.30**	**25,203**
Respite Care	**15 minute**	**959**	**1124**	**2.49**	**2,684,011**
Respite Care – Intensive	**15 minute**	**20**	**680**	**5.18**	**70,448**
Respite Care – Intensive	**Daily[1]**	**10**	**20**	**82.86**	**16,572**
Respite Care-Intensive-Out of home/R&B included	**Daily[1]**	**10**	**20**	**102.84**	**20,568**
Respite Care – Weekly	**per session**	**168**	**12**	**96.10**	**193,738**
Specialized Medical Equipment & Supplies - monthly	**monthly**	**15**	**12**	**165.55**	**29,799**
Specialized Medical Equipment & Supplies – purchase	**per episode**	**87**	**1**	**661.95**	**57,590**
Supported Employment	**15 minute**	**525**	**1120**	**6.51**	**3,827,880**
Supported Employment	**Daily[1]**	**272**	**204**	**34.00**	**1,886,592**
Supported Living	**15 minute**	**1200**	**1350**	**4.91**	**7,954,200**
Transportation - mileage	**per mile**	**37**	**1,991**	**0.34**	**25,047**
Transportation – daily	**Daily[3]**	**1,658**	**181**	**8.26**	**2,478,809**
Transportation – bus pass purchase	**per episode**	**118**	**6**	**73.22**	**51,840**
Waiver Support Coordination	**monthly**	**4050**	**12**	**230.99**	**11,226,114**
GRAND TOTAL (Sum of Column E)					**119,183,892**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS					**4050**
FACTOR D (Divide Grand Total by Number of Unduplicated Recipients					**29,428**

Notes:

1 All daily rates are based on services rendered for six hours or more per day. (Except Personal Budget Assistance)
2 Personal Budget Assistance is a single episode of service
3 Transportation-daily represents the daily rendering of transportation svcs.

APPENDIX G-2: FACTOR D

APPENDIX G-2: FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year: 1 ____ 2 ____ 3 ____ 4 ____ 5 __X__
(FY10)

WAIVER SERVICE COLUMN A	TYPE of UNIT	#Unduplicated Users COLUMN B	Avg. # Annual Unit/User COLUMN C	Avg. Unit Cost $ COLUMN D	TOTAL $ COLUMN E
Behavior Consultation Services I	15 minute	175	160	5.28	147,840
Behavior Consultation Services II	15 minute	50	160	9.20	73,600
Behavior Consultation Services III	15 minute	5	160	16.79	13,432
Chore Services	15 minute	124	648	3.17	254,716
Companion Services	Daily[1]	4	62	76.39	18,945
Companion Services	15 minute	6	3552	3.29	70,116
Day Supports (site/non-site)-Hourly	15 minute	88	2020	2.90	515,504
Day Supports (site/non-site) -Daily	Daily[1]	1564	195	52.96	16,151,741
Environmental Adaptations (home)	per episode	29	1	1939.72	56,252
Environmental Adaptations (vehicle)	per episode	8	1	1604.16	12,833
Extended Living Supports	15 minute	466	1416	3.62	2,388,679
Family Training and Preparation	15 minute	54	108	3.01	17,554
Family and Individual Training and Preparation	15 minute	77	56	5.28	22,767
Financial Management Services – Low Tier	Monthly	739	12	30.49	270,385
Financial Management Services – High Tier	monthly	135	12	99.70	161,514
Homemaker Services	15 minute	10	116	3.23	3,747
Living Start-up Costs	per episode	15	1	788.01	11,820
Massage Therapy	15 minute	70	12	13.86	11,642
Personal Assistance	15 minute	15	708	3.04	32,285

Personal Budget Assistance	**15 minute**	**200**	**336**	**5.01**	**336,672**
Personal Budget Assistance	**Daily[2]**	**1414**	**94**	**10.87**	**1,444,797**
Personal Emergency Response System – monthly	**monthly**	**49**	**12**	**29.84**	**17,546**
Personal Emergency Response System – installation	**per episode**	**45**	**1**	**56.29**	**2,533**
Personal Emergency Response System – purchase	**per episode**	**45**	**1**	**254.41**	**11,448**
Professional Medication Monitoring	**per episode**	**200**	**12**	**40.53**	**97,272**
Residential Habilitation-facility based	**Daily[1]**	**1214**	**335**	**146.09**	**59,413,342**
Residential Habilitation-Professional Parent/Host Home	**Daily[1]**	**131**	**319**	**112.62**	**4,706,277**
Residential Habilitation-Professional Parent-DCFS	**Daily[1]**	**92**	**319**	**98.35**	**2,886,376**
Respite Care	**Daily[1]**	**679**	**31**	**60.19**	**1,266,939**
Respite Care-Out of home/R&B included	**Daily[1]**	**10**	**31**	**82.93**	**25,708**
Respite Care	**15 minute**	**959**	**1124**	**2.54**	**2,737,907**
Respite Care – Intensive	**15 minute**	**20**	**680**	**5.28**	**71,808**
Respite Care – Intensive	**Daily[1]**	**10**	**20**	**84.52**	**16,904**
Respite Care-Intensive-Out of home/R&B included	**Daily[1]**	**10**	**20**	**104.90**	**20,980**
Respite Care – Weekly	**per session**	**168**	**12**	**98.03**	**197,628**
Specialized Medical Equipment & Supplies - monthly	**monthly**	**15**	**12**	**168.86**	**30,395**
Specialized Medical Equipment & Supplies – purchase	**per episode**	**87**	**1**	**675.19**	**58,742**
Supported Employment	**15 minute**	**525**	**1120**	**6.64**	**3,904,320**
Supported Employment	**Daily[1]**	**272**	**204**	**34.68**	**1,924,324**
Supported Living	**15 minute**	**1200**	**1350**	**5.01**	**8,116,200**
Transportation - mileage	**per mile**	**37**	**1,991**	**0.35**	**25,783**
Transportation – daily	**Daily[3]**	**1,658**	**181**	**8.42**	**2,526,825**
Transportation – bus pass purchase	**per episode**	**118**	**6**	**74.69**	**52,881**
Waiver Support Coordination	**monthly**	**4050**	**12**	**235.61**	**11,450,646**
GRAND TOTAL (Sum of Column E)					**121,579,625**
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS					**4050**
FACTOR D (Divide Grand Total by Number of Unduplicated Recipients					**30,020**

Notes:

1 All daily rates are based on services rendered for six hours or more per day.(Except Personal Budget Assistance)

2 Personal Budget Assistance is a single episode of service

3 Transportation-daily represents the daily rendering of transportation svcs.

APPENDIX G-2: FACTOR D

EXPLANATION OF D-CHART ESTIMATES

A. Reimbursement Units of Service for Covered Waiver Services

1. Behavior Consultation Service I, II, III- are new services. The estimates for utilization were obtained through discussion with DSPD regional office staff as to the approximate number of individuals with an observed need for this type of service. The rate was established based upon historical rates paid as on add-on rates for consumers who have utilized behavioral support services as a component of a bundled service (i.e. Community Living Support Service) under the State's previous waiver #0158-90. The covered services are reimbursed as 15-minute units of service and have a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

2. Chore Services - The Chore Services category was available under the general Chore/Homemaker category in the previous waiver #0158-90. The State has chosen to separate the two components into distinct services. The Chore Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a 15-minute unit of service and is available in both the agency based provider model and the self-directed services model. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

3. Residential Habilitation (formerly Community Living Supports) – The Residential Habilitation Service D- factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, of the previously titled Community Living Supports Services which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. Services rendered for six hours or more per day are billed at the daily rate.

For the Residential Habilitation-Professional Parent/Host Home service, the rate for this service was derived from an examination of historical data pertaining to the delivery of a similar service to a similar target population within the State's existing waiver #0158-90. This historical data was trended forward to the first year of the renewal period (FY06).

For the Residential Habilitation-Professional Parent services provided to

children in the custody of the State of Utah: Department of Human Services, Division of Child and Family Services (DHS/DCFS), the rate was established by deducting the amount paid by the Division of Child and Family Services for basic supervision and maintenance from the general Residential Habilitation-Professional Parent/Host Home services rate. Residential Habilitation-Professional Parent services delivered to children in the custody of DCFS are billed under a distinct, separate billing code.

This daily rate has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

4. Companion Services – Companion Service is a new service. The estimates for utilization were obtained through discussion with DSPD regional office staff as to the approximate number of individuals with an observed need for this type of service, and for whom a service (i.e. Community Living Support Service) in which companion service is available, are not currently utilized. The rate was established based upon historical rates paid for the companion services component of a bundled service (i.e. Community Living Support Service). The covered service is reimbursed as both a 15-minute unit and a daily rate unit of service. The 15-minute unit of service is available in both the agency based provider model and a self-directed services model. Services rendered for six hours or more per day are billed at the daily rate. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

5. Day Supports – Site and Non-Site Based - The Day Supports Service D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

6. Day Support – Site and Non-Site Based - Daily – The Day Supports- daily level of service was available under the general Day Supports category in the previous waiver #0158-90. The State has chosen to separate the two components into distinct services. The D- factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a daily unit of service and has a set Maximum Allowable Rate that is determined in accordance with

Appendix G-9.

7. Environmental Accessibility Adaptations – Home, Personal, Vehicle – The Environmental Accessibility Adaptations D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a per service unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

8. Extended Living Supports – The Extended Living Supports Service was available under the general Community Living Supports category in the previous waiver #0158-90. The State has chosen to divide the separate components into distinct services. The covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

9. Family Training and Preparation Services – Family Training and Preparation Services D- factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

10. Family and Individual Training and Preparation Services- Family and Individual Training and Preparation Services D- factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, combining Family Training and Supports with Self-Directed Services which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a per episode unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

11. Financial Management Services-Low Tier and High Tier – This is a new service. The estimates for utilization were based on historical data deriving from utilization of the fiscal management agent utilized in the previous waiver #0158-90 and reimbursed as a percentage of the total rate paid to employees of those choosing to participate in self-administered services. A sophisticated multivariate cluster analysis of the historical data from the final year of the previous waiver yielded the identification of two clusters of participants, one distinguished by few transactions and few

employees, and the other distinguished by a high number of transactions and employees. Rates were established by calculating the proportion of total transactions attributable to each cluster, and using that proportion to allocate a portion of the total expenditures for Financial management service in the final year of the previous waiver, divided by the number of participants in each cluster divided by 12 months, yielding per member per month (PMPM) rates for each cluster.

12. Homemaker Services – The Homemaker Services category was available under the general Chore/Homemaker category in the previous waiver #0158-90. The State has chosen to separate the two components into distinct services. The Homemaker Services D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a 15-minute unit of service and is available in both the agency based provider model and the self-directed services model. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

13. Living Start-up Cost Services – Living Start-up Cost Services is a new service. Utilization and cost estimates are based upon experiences from the last five years in which DSPD paid for this type of service through "state-only" funds. The covered service is reimbursed as a per service unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

14. Massage Therapy Services – Massage Therapy Services D- factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

15. Personal Assistance Services – The Personal Assistance Services Service D- factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

16. Personal Budget Assistance Services – Personal Budget Assistance is a new service. Utilization is based on an estimate that approximately 15% of the individuals receiving supported living and 6% of others receiving

in-home supports may have the need for this service. The covered service is reimbursed as a 15-minute unit of service, or as a single daily episode of service and each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

17. Personal Emergency Response Systems – Install/Monthly Fee/Purchase – The Personal Emergency Response Systems D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service has three component units of service: (a) installation and testing as a per unit item, (b) ongoing service fee as a monthly unit, and (c) purchase as a per item unit. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

18. Professional Medication Monitoring – Medication Monitoring is a new service. Utilization is based on an estimate that approximately 10% of the individuals receiving supported living and other in-home supports may have the need for medication monitoring by a medical professional. The covered service is reimbursed as a per episode unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

20. Respite Care – Routine Level - The Respite Care Routine Service was available under the general Respite Care Services category in the previous waiver #0158-90. The State has chosen to divide the separate components into distinct services. The covered service is reimbursed as both a 15-minute unit and a daily rate unit of service and is available in both the agency based provider model and a self-directed services model. Services rendered for six hours or more per day are billed at the daily rate. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9. In the case of respite care services that are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Out of the home/Room and Board included" billing code.

21. Respite Care – Intensive Level- Respite Care Intensive Level is a new service. Utilization is based on an estimate that approximately 1% of the individuals receiving respite services would require respite services from a more skilled professional. The covered service is reimbursed as both a 15-minute unit and a daily rate unit of service and is available in both the agency based provider model and a self-directed services model. Services rendered for six hours or more per day are billed at the daily rate. Each component has a set Maximum Allowable Rate that is determined in

accordance with Appendix G-9. In the case of respite care services that are rendered out of the consumer's private residence in a setting approved by the State, this service will be billed under a specific "Respite Care-Intensive-Out of the home/Room and Board included" billing code.

23. Respite Care – Weekly - The Respite Care Weekly Service was available under the general Respite Care Services category in the previous waiver #0158-90. The State has chosen to divide the separate components into distinct services. The covered service is reimbursed as a per session unit of service and is available in both the agency based provider model and a self-directed services model. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

24. Specialized Medical Equipment – Monthly Fee/Purchase The Specialized Medical Equipment Service D-factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service has two component units of service: (a) ongoing service fee as a monthly unit and (b) purchase as a per item unit. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

25. Supported Employment - The Supported Employment D- factor for FY06 is based on HCFA Form 372 initial reports for years 3 & 4 of waiver #0158-90, which serves a similar target population, trended forward to the first year of the renewal period (FY06) with adjustments for variance from the two-year trend. The covered service is reimbursed as both a 15-minute unit and a daily unit of service. Services rendered for six hours or more per day are billed at the daily rate. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

26. Supported Living Services - The Supported Living Service was available under the general Community Living Supports category in the previous waiver #0158-90. The State has chosen to divide the separate components into distinct services. The covered service is reimbursed as a 15-minute unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

27. Transportation Services – Transportation Services has three component units of service: (a) self-directed services model as a per mile unit, (b) agency based provider model as a daily unit, and (c) multi-pass public transit system model as a per service unit. Each component has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

28. Waiver Support Coordination – The Support Coordination service is reimbursed as a flat rate monthly unit of service and has a set Maximum Allowable Rate that is determined in accordance with Appendix G-9.

APPENDIX G-3: METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Residential Habilitation

Following is an explanation of the method used by the State to exclude Medicaid payment for room and board in Residential Habilitation.

Medicaid reimbursement rates paid to Residential Habilitation providers for habilitation services will be individualized based upon the assessed needs of the individual. The daily rate paid to the Residential Habilitation providers cover only the cost of the habilitation services.

Individuals are responsible to pay room and board directly to their landlord and purchase food from their personal income. Individuals having insufficient personal income to cover their entire room and board costs are assisted by a State funded program in which the Division of Services for People with Disabilities assists individuals in paying these costs. The daily Medicaid reimbursement excludes all room and board costs.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that

meets State standards specified in this waiver.)

The State will cover the cost of room and board as part of respite services when provided in a Medicaid certified NF or ICF/MR, or when provided in a community setting other than the natural home of the individual.

The State utilizes a specific billing code under the respite services category with which to bill for respite services that include room and board as a component of the rate.

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Respite Care

APPENDIX G-4: METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5: FACTOR D'

LOC: **ICF/MR**

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5: FACTOR D' (cont.)

LOC: **ICF/MR**

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 lag reports for years 2 & 3 of waiver # 0158-90. The results trended forward to the first year of the renewal period (FY06) are $5,741. An annual inflation factor of 2.0% is added for each year of waiver years two through five to compute the cost neutrality formulas for those years.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

APPENDIX G-6: FACTOR G

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for year 2 & 3 of waiver #158.90, which reflect costs for an institutionalized population at this LOC.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__X__ Other (specify):
Based on actual expenditures during waiver years 3 & 4 of waiver #158.90, which reflect costs for an institutionalized population at this LOC.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7: FACTOR G'

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution)), which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7: FACTOR G' (cont.)

LOC: **ICF/MR**

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 lag reports for years _____of waiver.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify): Based upon actual expenditures for G' for waiver years 3 & 4 of waiver of 158.90. The result trended forward to the first year of the renewal period (FY06) is $7,652. An annual inflation factor of 2.0% is added for each year of waiver years two through five to compute the cost neutrality formulas for those years.

APPENDIX G-8: DEMONSTRATION OF COST NEUTRALITY

LOC: **ICF/MR**

YEAR 1

FACTOR D:	$27,712		FACTOR G:	$66,003
FACTOR D':	$ 5,741		FACTOR G':	$ 7,652
TOTAL:	$33,453	<	TOTAL:	$73,655

YEAR 2

FACTOR D:	$28,288	FACTOR G:	$67,323	
FACTOR D':	$ 5,865		FACTOR G':	$ 7,805
TOTAL:	$34,153	<	TOTAL:	$75,128

YEAR 3

FACTOR D:	$28,853		FACTOR G:	$68,669
FACTOR D':	$5,973		FACTOR G':	$ 7,961
TOTAL:	$34,826	<	TOTAL:	$76,630

YEAR 4

FACTOR D:	$29,428		FACTOR G:	$70,042
FACTOR D':	$ 6,092		FACTOR G':	$ 8,120
TOTAL:	$35,520	<	TOTAL:	$78,162

YEAR 5

FACTOR D:	$30,020		FACTOR G:	$71,443
FACTOR D':	$ 6,214		FACTOR G':	$ 8,282
TOTAL:	$36,234	<	TOTAL:	$79,725

APPENDIX G-9: WAIVER SERVICES PROVIDER REIMBURSEMENT RATE SETTING METHODOLOGIES - MAXIMUM ALLOWABLE RATES

A. DEPARTMENT OF HUMAN SERVICES RESPONSIBILITY TO SET WAIVER RATES UNDER CONTRACT WITH THE DEPARTMENT OF HEALTH

The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. Since DHS usually sets rates at or close to the statistical mean, DHS also assures compliance with Medicaid payment requirements. Medicaid requires that rates for many services not exceed the prevailing charges. Prevailing charges are described at 42CFR § 405.504 and are set at the 75 percentile. The CFR lists other criteria regarding reasonable cost for Medicaid cost-of-service contracts when prevailing charge regulations do not apply. These are found and described at 42CFR § 405.501 and may be used as applicable.

B. AUTHORITY UNDER STATE DIVISION OF FINANCE RULE 33-3-217

DHS has the authority to set rates under the Utah State Department of Administrative Services (DAS), Division of Finance, Rule 33-3-217. This rule sets forth the parameters for open-ended, rate setting within DHS. Requirements for this rule are listed below.

1. All qualified providers can have a contract (no guarantee of placements), or in other words DHS must have a Request for Proposal (RFP) process that meets purchasing requirements.

2. DHS has a rate setting process that establishes reasonable rates.

3. DHS provides for due process to providers that have complaints.

C. COST PRINCIPLES

When setting rates and establishing budgets for cost of service contracts, DHS uses federal and department cost principles. These are described in the Bureau of Contract Management, Contract Information Manual, found on the DHS web site at http://www.hsofo.state.ut.us/Contract.htm. Additional references are given there for circulars containing the federal cost principles. These are issued by the federal Office of Management and Budget (OMB).

D. RATIONALE

1. The Department of Human Services has opted to provide many services using a fixed rate for multiple providers. This allows DHS the flexibility of using many providers across the state and increasing placement options across the state and

within communities. Multiple providers are able to more readily respond to changing service demands. The DHS Bureau of Contract Management (BCM) has overall responsibility for the rate setting process within DHS. The setting of rates is based on a cooperative process between BCM and each division within DHS. Each division is responsible to determine and define the service code and service components within each code. When a division establishes a new service code, they work with BCM to determine the rate to be set for that service. BCM also reviews rates on an ongoing basis and sets (establishes) a DHS Maximum Allowable Rate (MAR) level or Cap for that rate.

2. Each division determines the actual amount to be paid to providers that is not more than the MAR rate level. Divisions make this determination based on available budget and other considerations. Divisions continue to develop new services and to determine the initial payment rate (provisional rate) for those services. BCM will review the proposed new service code and consult with the division and DHCF on determining an acceptable initial rate for the service. BCM gives authorization for the initial (provisional) rate and forwards a rate request form to finance for input on USSDS and to DCHF for input on MMIS.

E. OVERVIEW OF THE RATE SETTING METHODOLOGY

1. There are several methods DHS uses to reimburse providers of services to DHS personpersonpersons. The DHS Rate Handbook outlines the procedures for setting rates for DHS providers. These methodologies include the use of: (1) the Request for Proposal (RFP) process for cost-reimbursement contracts, (2) sole source contracts, and (3) rate-based unit-of-service contracts. Though the DHS Rate Handbook addresses all of these methodologies, in practice, the State does not award sole-source contracts for the provision of waiver services. The Rate Handbook provides the authority and methodologies used for setting and reviewing the rates paid to providers using rate-based unit-of-service contracts with DHS.

2. DHS rates are set and paid on a prospective basis. This means that rates are set based on the market. Although actual costs may decrease or increase, providers are not expected or allowed to refund or bill for differences between actual current costs and rates. Rates are set based on the current market value of services rendered. This is sometimes referred to as the prevailing charge or rate. The nature and requirements of each of the services are defined by the various Divisions within DHS in accordance with the general description of those services outlined in the RFP and contract. Determination of current market value of services is determined by surveying current providers of such services to determine charges for those services or, in the alternate, the actual cost to provide services is used to set rates in lieu of market charges.

3. When data show the market value of services to be tightly clustered among various service providers, statistical measures of central tendency (e.g., mean,

median, mode, and/or weighted average) are used. This establishes the most equitable rate that will assure a sufficient supply of service providers and concurrently pay a fair market rate. Measures of central tendency are best applied when data are clustered or normally distributed. When market conditions do not validate these assumptions, other measures will be allowed for use in setting rates for services including cost accounting measurements and/or those commonly used under Medicare or Medicaid programs. This also applies to rates receiving Medicaid reimbursements.

4. To insure the greatest possible integrity of data supplied by providers, the staff from BCM or the DHS Bureau of Internal Review and Audit may audit data. In addition, non-representative (outlier) survey data may also be dropped from the survey if it is deemed to unfairly bias the results. An example of this would be a small service provider with exceptionally high or low rates that are not representative of the industry and market at large.

F. RATE SETTING METHODS

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Because DHS provides services using various funding sources, including Title XIX, Title XX, Title IV-E among others, adjustments to the following processes may be deemed necessary on occasion to comply with funding requirements. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors, or division budget constraints, etc.

1. Existing Market Survey or Cost Survey of Current Providers.

   This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

   The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service,

etc) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

G. DATA VALIDATION

The Utah Department of Human Services strives to utilize the most accurate information in the rate setting process. DHS uses various methods to validate data used in setting rates; these include both internal and external statistical and accounting tests. The specific methods used are determined by the type of data collected (i.e., from Cost Surveys, Market Surveys, Comparative Analysis, etc.), historical reliability of data sources and demands on staff. The type of tests used are based on the nature of the rate being set. Various methods of validation are explained in the DHS Rate Handbook.

H. COST OF LIVING ADJUSTMENTS (COLA'S)

1. Cost of Living Adjustments (COLA's) to the DHS MAR rate level are made annually, effective with the beginning of each State fiscal year. In general, changes in the twelve month period ending in June (base period) are reflected in an adjustment for the State fiscal year beginning twelve months later (effective date). This interim period is used to collect data from the base period, as it becomes available. The COLA adjustment is scheduled to be completed by the end of the calendar year to allow COLA information to be used in planning for the upcoming State fiscal year.

2. Changes in the MAR rates are based on changes in the cost of living as determined by broad based cost of living indices such as the Consumer Price Index (CPI-u) as published by the U.S. Department of Labor, or more representative local indices such as the Department of Workforce Services index of average Utah wages. The cost of living allowance is calculated by determining the percentage change in the index (or indices) and then applying that percentage change to the rate or rate components of established MAR rates. The MAR rates revisions are scheduled to be completed and published prior to the start of each State fiscal year.

3. COLA changes to a MAR are likely to be different from legislative rate changes funded in Division budgets. Legislative funding adjustments to Division rates are usually budget constrained and reflect a political perspective and may not be related to actual cost changes in rate components.

I. SUPPORT COORDINATION SERVICE MONTHLY RATE

1. The Support Coordination covered waiver service provider rate is calculated using the cost survey of current providers methodology in general but includes an added procedure in which each fiscal year the State Medicaid Agency establishes specific cost center parameters to be used in calculating the annual MAR for waiver Support Coordination.

2. Support coordination activities covered by the MAR must be consistent with the definition of Support Coordination contained in Appendix B-1, and the Medicaid Home and Community-Based Services for Individuals with Development Disabilities or Mental Retardation provider manual.

3. Allowable Cost Centers

    a. Annual non-supervisory support coordination labor costs.

    b. Annual non-supervisory support coordination non-labor costs.

    c. Annual first line supervisory employee labor costs.

    d. Annual first line supervisory employee non-labor costs.

    e. Administrative costs associated with provision of support coordination service.

4. Support Coordination MAR Formula

$$\text{Monthly per person rate} = \frac{[(a + b + c + d + e) / (\#\text{ person receiving spt. coord.})]}{12 \text{ months}}$$